TWENTIETH ANNIVERSARY OF MEDICARE AND MEDICAID: AMERICANS STILL AT RISK

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

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TWENTIETH ANNIVERSARY OF MEDICARE AND MEDICAID: AMERICANS STILL AT RISK

TUESDAY, JULY 30, 1985

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:43 a.m., in room 345, Cannon House Office Building, Hon. Edward R. Roybal (chairman of the committee) presiding.

Members present. Representatives Roybal, Pepper, Biaggi, Bonker, Hughes, Volkmer, Reid, Sisisky, Manton, Robinson, Rinaldo, Jeffords, McCain, Lightfoot, Fawell, Meyers, and Schuette.

Staff present: Fernando Torres-Gil, staff director; Gary Christopherson, professional staff member; Nancy Smith, professional staff member; Christinia Mendoza, professional staff member; Austin Hogan, communications director; Carolyn Griffith, staff assistant; Judith Lee, executive assistant; Jacquelyn Hedlund, intern; and Paul Schlegel, minority staff director.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The CHAIRMAN. The committee will come to order.

The purpose of this hearing is to examine the plight of those aging Americans who are still at financial risk, even with the help of Medicare and Medicaid.

The Medicare and Medicaid Programs were enacted 20 years ago today. Most of all, we had planned to protect America's elderly and poor from the devastation of costly illness.

Unfortunately, 20 years later, aging Americans remain at high financial risk.

The purpose of today's hearing is to examine the plight of those aged Americans who are still at great financial risk even with the help of Medicare and Medicaid.

While our primary focus today is on the elderly, we must not lose sight of another American tragedy. Among our nonelderly, 20 to 30 million are uninsured against the high cost health care. Millions more are underinsured against the ravages of expensive, long-term illnesses. Let no one doubt that we are committed to removing the unacceptable financial risks facing them as well.

When Medicare and Medicaid were enacted 20 years ago today, most thought that we had finally protected America's elderly and poor from the devastation of costly illness. Unfortunately, 20 years later, aged Americans remain at high financial risk.

This year the elderly will spend more of their income for health care than they did before Medicare and Medicaid began 20 years ago. And it gets worse. In committee projections released today, we estimate that, America's aged will be spending $2,583 per person in 1990 for health care—a whopping 18.9 percent of their limited incomes.

Of all older Americans at risk, those in the highest category of risk are the elderly who fall victim to long-term, disabling illnesses such as Alzheimer's disease. Why? It is because this Nation has consistently failed to come up with a coherent financing system for long-term care.

In a special study prepared for the committee, we have measured the reach of this financial risk and found that it extends high into the middle class. Nearly two out of three elderly persons living alone will impoverish themselves after only 13 weeks in a nursing home. This is one of the deplorable and frightening findings of Dr. Laurence Branch's study of Massachusetts elders.

No one is immune to this risk. Today, our parents and grandparents, for those of us fortunate enough to have them, are still at risk. Today, many of us in this room are still at risk. Tomorrow, our children and grandchildren will still be at risk—if we fail to act.

I say we must act prostively and quickly. We must limit elderly out-of-pocket costs to no more than the current 15 percent of income. We must enact a coherent policy for long-term care.

So on this somewhat "bittersweet" occasion, while we celebrate all that Medicare and Medicaid have done for America's aged and poor, we must also take steps to complete the unfinished agenda of protecting uninsured and underinsured Americans still at risk.

Two studies has been made on behalf of the committee. The first study, conducted by the committee, outlines the rapid rise in the elderly's out-of-pocket health care costs through 1990. That study is made available to the press and to all who wish to read it.

[See Appendix, p. 35.]

The second study assesses the risk of impoverishment facing those elderly needing long-term care across income levels.

[See Appendix, p. 51.]

At this time, I would like to thank the authors of the second study. Two of the three authors of this report are with us today. I would like to introduce them to you, and, if they are here, have them stand and be recognized.

They are Dr. Laurence Branch from the Harvard Medical School.

Dr. BRANCH. Thank you, sir.

The CHAIRMAN. Dr. Daniel Friedman from Blue Cross Blue Shield of Massachusetts.

Please stand, Dr. Friedman.

The CHAIRMAN. Both of these gentlemen will be available for questions by the press or anyone who wishes to seek further information.

May I thank them for the work that they have done, and for the tremendous good that they are doing not only for those of us on this committee but for the Nation as a whole.

Before introducing the members of the committee who are present, I would like to recognize our first witness, for it is my understanding that he is somewhat busy.

He is the majority leader of the House of Representatives, and I know for a fact that he is very busy.

I therefore recognize at this time the Representative from the State of Texas, Hon. Jim Wright.

STATEMENT OF HON. JIM WRIGHT, MAJORITY LEADER OF THE U.S. HOUSE OF REPRESENTATIVES, A REPRESENTATIVE FROM THE STATE OF TEXAS

Mr. WRIGHT. Mr. Chairman, thank you very much for this privilege.

We have much to celebrate today. For 20 years, Medicare and Medicaid have been the difference between life and death for many millions of our fellow citizens.

Most of the 30 million elderly and disabled Americans have had access to lifesaving health care that would not have been available to them during the long years prior to Medicare. And Medicaid enables 22 million of America's poor to get medical attention that they so desperately need.

It is a common tendency, I think, to take good health for granted. It is one of those blessings that go virtually unnoticed until they are gone. We have a natural attitude to avoid contemplating illness and injury, because those things make us a little bit uncomfortable.

Serious illness is a serious business. It can be financially as well as physically devastating. Just think how frightening illness can be to the elderly and the poor, the handicapped, the disabled. For these people, a stay in the hospital too often has meant far more than physical discomfort or incapacitation; for some, it has meant impoverishment, and the mental anguish that is brought on by the dread of financial ruin.

To a large extent, Medicare and Medicaid have helped to lift that heavy burden from the shoulders of the elderly and the poor.

And, yet, despite the enormous strides that we have made in the past 20 years, many challenges still confront us.

We have faced a concerted effort in recent years to shift a greater financial burden back onto those who can least afford it. Higher premiums and copayments and deductibles add up to enormous out-of-pocket expenses for Medicare and Medicaid beneficiaries.

And, even as we sit here today, in the budget process and the conference committee between the House and the Senate, there are very significant differences in the way the elderly and the poor and the needy and the sick will be treated.

There are efforts on the part of the administration right now to make it harder to get home care, the thing that is preventive and that costs so much less to the Government and often is so much more helpful and more rewarding to the patient than long stays in the hospital.

We have tried to hold the line against these charges upon our barricades. Some of them are promoting thoroughly counterproductive measures, but the pressure has been great.

Back in 1966, before Medicare and Medicaid were fully implemented, the elderly were spending 15 percent of their income on health care.

By 1977, largely because of the success of Medicare and Medicaid, that percentage had declined to 12 percent, and that amounts to an enormous stride.

But recent estimates suggest alarmingly that, by 1990, the elderly may have to spent 19 percent of their income on medical care.

Now, that does not mean that we have not made any progress. More people are getting care, and more are availing themselves of preventive care. But it clearly does mean that there still are unmet health care needs.

And I want to congratulate you, Mr. Chairman, and the entire Aging Committee, for continuing to raise these issues here in Congress. You have helped us in recognizing that very many current Medicare and Medicaid beneficiaries are still at great risk, especially in the area of long-term health care. A long-term disabling illness, such as Alzheimer's disease, would financially devastate many millions of elderly in this country—in fact, most Americans.

This committee has been in the forefront of our national conscience. Your leadership is indispensable, as the Congress contemplates what we should do to meet the health care needs of the elderly and the indigent.

And we will have to consider how to go about formulating a national long-term health care policy to meet these needs; and I, for one, eagerly await the recommendations of this committee. I want to work closely with you in devising a new plan of action.

This 20th anniversary, Mr. Chairman, offers a chance to reflect back, to consider what we have accomplished, and to examine the needs for the future.

There is an unfinished agenda that cries out for our attention. I know this committee will not turn a deaf ear to the cries of the elderly and the poor. And I trust, as well, that the entire Congress will be attentive and responsive to this committee's recommendations.

Franklin D. Roosevelt called the Social Security System on the day that he signed the bill, "the cornerstone of a structure which is being built, but is, by no means, complete."

Twenty years ago, we added Medicaid and Medicare to that venerable structure. Today, it falls to us to do all we can to ensure that this structure of compassion adequately responds to the needs of those who have nowhere else to turn.

And so, I congratulate you, Mr. Chairman, and your committee, for this day of commemoration, and for your vision in looking ahead to fill the still unmet needs.

Thank you.

The CHAIRMAN. Thank you, Mr. Wright.

Ladies and gentlemen, Congressman Jim Wright has always been a strong supporter of Medicare and Medicaid. I am sure that in the weeks and months and years to come he will continue in that effort; and, as a leader in the House of Representatives, will be most instrumental in passing the necessary legislation to remedy the situation as we see it today.

Thank you for your comments.

Now, the Chairman would like to recognize members of the committee that are present this morning.

The Chair would like to introduce Congressman Jeffords.

STATEMENT OF REPRESENTATIVE JAMES M. JEFFORDS

Mr. JEFFORDS. Thank you, Mr. Chairman.

First, I would like to ask that the statements of Mr. Rinaldo and Mr. Hammerschmidt be placed in the record at this time.

Mr. Chairman, I want to thank you for having us here this morning for this celebration and for the important hearings that are about to follow.

We are proud of what has been accomplished in the past 20 years, but today we will look at what is left that needs to be done.

We are not even close to solving the needs of the elderly in the health care area, but we have had a significant—in fact, a magnificent—beginning.

So now, let us listen to what needs to be done, Mr. Chairman. That is the purpose for being here today.

Thank you.

The CHAIRMAN. Thank you.

The Chair would like to suggest that each member have time to make a short, 1-minute speech. But that was less than 1 minute, and I thank the gentleman very much.

[The prepared statements of Mr. Rinaldo and Mr. Hammerschmidt follow:]

PREPARED STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Mr. Chairman, Medicare has played a vital role in improving the health of America's senior citizens.

I don't think there can be any question that we must continue to stengthen this program to help the over 30 million Americans who depend on it to receive their health care needs.

It is also appropriate for our committee and others to commemorate the anniversary of this program.

The past 20 years have been a tremendous success in many ways. But at the same time, we cannot ignore those areas where the program can be improved.

I am looking forward to the testimony we will receive and want to welcome the witnesses who are with us here this morning.

PREPARED STATEMENT OF REPRESENTATIVE JOHN PAUL HAMMERSCHMIDT

Mr. Chairman, with the passage of Medicare legislation in 1965, Government was acknowledging its obligation to provide protection to older Americans from the physical and economic hardships of illness.

I remember that when Medicare legislation was passed, Americans, for the first time, felt confident that their older family members and they, in their old age, would be assured fo basic health care. I don't think that anyone can deny that millions of people are receving care that would be unattainable without this law. However, 20 years after the enactment of Medicare, it is evident that despite expenditures of over $60 billion last year we are not providing comprehensive medical care for the elderly, nor are we protecting their incomes from the effects of chronic and catastrophic illniesses. In regard to comprehensive care, I refer to the fact that Medicare still excludes payments for nursing home care (unless it is part of an acute episode), preventive examinations, eyeglasses, prescriptions, and prosthetic devices. Furthermore, average out-of-pocket costs have gone from $234 in 1966 to $1,059 in 1984, excluding premium costs.

I see today's hearing not so much as a fact finding mission, but rather, as an opportunity to renew our commitment to providing thorough medical care which is

responsive to the acute and long-term health conditions experienced by millions of older Americans.

The CHAIRMAN. The Chair now recognizes "Mr. Senior Citizen" himself—the gentleman from Florida.

What is your name, sir?

Mr. PEPPER. Claude Pepper.

The CHAIRMAN. Mr. Pepper.

STATEMENT OF REPRESENTATIVE CLAUDE PEPPER

Mr. PEPPER. Mr. Chairman.

And all you ladies and gentlemen.

We have a lot of reasons to be proud and to be grateful for what we now have.

We think of the millions of people who have received medical care while they were ill, through Medicare and through Medicaid.

And, yet, we cannot forget those who have Alzheimer's disease who do not receive any care under Medicare.

We cannot forget that elderly people who receive home care do not receive enough; and, second, they do not receive free the drugs that the doctors prescribe for their use in the home.

They still do not receive hearing aids, and eyeglasses, medicines, or foot care.

And those who receive Medicaid have to be almost destitute to be eligible for their share. As I recall, it actually cannot exceed $1,500.

And so we have such cases—why, I remember back there in 1965 when we passed the Medicare bill and Medicaid, we were so hopeful that they would substantially meet the medical needs of the elderly people of this country.

At that time, the elderly were spending 20 percent of their own private income for their medical care. That was before Medicare and Medicaid. They are now spending the same percentage, the same percentage of their private income they were spending before that legislation came into being.

I will not belabor the point except to say that I think all of us agree that we cannot be true to the American ideal of what America can do for its people until we develop an American system under which, by paying all the way it can—each penny—every man, woman, and child in America can have the medical care that he or she should have.

I think that is a right, everyone's right.

For the last 5 years, we have been so busy fighting off the attack upon what we have, we have not had much time to perfect what we have into something that we could do.

These assaults upon Medicare and Medicaid, reducing the amounts available by billions of dollars every year, are constantly deterring the accomplishments.

Will somebody stop.

And we will accept those institutions as institutions that will no longer remain in effect.

Then we can turn our hope, our efforts, and our hearts toward perfecting what we have, into something that should be—the American dream.

I thank you all.

The CHAIRMAN. Thank you, Mr. Pepper.

Mr. McCain.

Mr. MCCAIN. I have a statement which I ask unanimous consent to be entered into the record.

The CHAIRMAN. Without objection, your written statement will be included in the record at this point.

[The prepared statement of Mr. McCain follows:]

PREPARED STATEMENT OF REPRESENTATIVE JOHN MCCAIN

Today, we are commemorating the twenty year enactment of a landmark piece of legislation that provides relief for our senior citizens when purchasing health care services. The legislation that I am referring to created our first nationwide health service program, that of Medicare.

Recognizing that the cost of health care falls hardest on the elderly, Congress amended title 18 of the Social Security Act in 1965 to create the Medicare program. It is the largest personal health care financing program in the United States and, except for Social Security, the largest entitlement program in the Federal budget. This program assists nearly 28 million senior citizens and about three million disabled individuals. Protection is available to all insured persons without regard to their income or assets.

Since its enactment, Medicare has contributed immeasurably to ensure access to appropriate and affordable health care. This health care program pays for many types of health care services, such as inpatient hospital care, skilled nursing care, home health services, physician services, the services of chiropractors, podiatrists, and dentists, laboratory and diagnostic tests, x-ray and radiation therapy, artificial devices, ambulance services, and certain other services.

However, Congress must continue to carefully monitor this program. Cost, access, and adequate coverage must continually be addressed in order to meet the changing needs of the elderly. Another financial crisis within the health care trust funds must not occur. Escalating health care costs and the growth in our senior population, led to rapid depletion of the Medicare funds, and financial difficulties in 1982 and 1983. Fortunately, immediate measures were taken to resurrect the health care trust funds and put them back on firm financial footing. The prospective payment system was enacted to control expendtitures from the hospital insurance trust fund. Under this payment system, hospitals are pre-paid on the basis of diagnostic related groups. Additionally, Congress responded to need for less costly, and different forms of health care by expanding benefits to include hospice and health maintenance organization services.

I believe that the Members of this Body are committed to the health and well-being of our nation's Senior Citizens. This means the commitment to maintain the integrity of the Medicare program. Members of Congress will continue to address the Medicare trust funds and find ways to control the escalating cost of health care while ensuring access to high quality health care services.

The CHAIRMAN. Mr. Manton.

STATEMENT OF REPRESENTATIVE THOMAS J. MANTON

Mr. MANTON. Thank you, Mr. Chairman.

First, I would like to thank you, the Speaker and Mr. Pepper and the leaders of the aging organizations for sponsoring this morning's ceremony.

The 20th anniversary of Medicare and Medicaid is indeed a memorable occasion.

Twenty years ago, President Johnson signed into law the Medicare and Medicaid Programs. As a nation, we have accomplished much in terms of providing quality health care for the older Americans, disabled Americans, and impoverished Americans.

However, looking back on the accomplishments of the last 20 years, one cannot help but note some problems that will only worsen as time goes on.

Many Americans are unprotected, or underprotected. When it comes to providing proper coverage for the long-term or full-health care we have a long way to go.

Most Americans remain extremely vulnerable to financial ruin when a long-term illness strikes.

At this morning's ceremony, we heard about where Medicare and Medicaid started and the accomplishments in the last 20 years.

Now, it is time to take a look at what we can and should do in the next 20 years. I am looking forward to hearing today's testimony. I would like to commend Chairman Roybal for calling today's hearing and for his commitment on behalf of America's senior citizens.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Fawell.

STATEMENT OF REPRESENTATIVE HARRIS W. FAWELL

Mr. FAWELL. Thank you, Mr. Chairman. I have just a brief comment.

I look at this 20th anniversary of Medicare and Medicaid, and I recall I was in the Illinois Legislature when this program came into being, with some awe, as some villain. I look at it with awe because a lot of progress certainly has been made; but, with ambivalence because it seems as though, as every person here in Congress knows, everything we look at regarding the calendars with our reports is within the context of a massive Federal debt.

I do not mean to put a wet blanket on the gathering here today, but we simply cannot accept forget that we have a national debt now that is closing in on $2 trillion and $200 billion annual deficits which appear to be almost customary. One debt that we seemingly just cannot is the $150 billion per year interest we pay to service the national debt.

We have monetary problems which almost mean that no budget at all can be agreed upon; except that the one thing we have agreed upon here for both parties is that we will pile on another $700 billion on our national debt within the next 3 years, so that we will be at least reaching $305.5 billion by 1988.

Mr. Chairman, I must confess. I do want to listen very seriously to all that is to be said. That specter bothers me. I know it bothers all of us a great deal. I think it is something that we must have in mind.

The CHAIRMAN. Mr. Robinson.

STATEMENT OF REPRESENTATIVE TOMMY F. ROBINSON

Mr. ROBINSON. Thank you, Mr. Chairman.

First off, I would like to thank you and Mr. Pepper for working so hard over the years to make it possible for my mother and grandmother to have adequate health care through Medicare.

As you know, Mr. Chairman, I have only been here for a while, but I pledge to you that I will do all I can to make sure that this sense of courage of our senior citizens is carried on for many years to come.

I want to also state this morning that I am very concerned about the tension that is developing in this country between our physicians and our hospitals and the patients and the DRG program; the lack of adequate coverage for long-term health care.

I mention those because I have been studying them, but we still have a long way to go, and I want to tell you and our senior citizens that you can count on me when you need me to help you lead the fight that you have been fighting so many years.

The CHAIRMAN. Ms. Meyers.

[No response.]

The CHAIRMAN. Mr. Lightfoot.

[No response.]

The CHAIRMAN. Ms. Meyers.

STATEMENT OF REPRESENTATIVE JAN MEYERS

Ms. MEYERS. Mr. Chairman, I am very pleased to have been part of this ceremony today. You can count on me, too.

I have served 12 years in the Kansas Senate and was chairman of public health and welfare there and worked very actively with Medicaid and Medicare Programs at the State level.

I do know that both programs have provided such tremendous good for so many people. I hope that we can keep working so that we devise some ways so that we can provide Medicaid assistance to people without requiring them to spend themselves down to poverty before they receive this kind of help.

We have, however, in the Medicaid program grown and changed over the years, and we have provided the Medicaid grant waiver from the Federal level so that we now are able to provide a whole variety of home- and community-based services for people.

In Medicare, the program has been, of course, of such tremendous value to so many elderly people; has provided them with so much better access to care.

The Government money in the Medicaid and Medicare Programs undoubtedly has fueled some of the high costs in medicine; and now we just have to keep working so that we can moderate those high costs, and still keep providing the good programs.

These are essential programs and good programs, and require hard work and thoughtful planning to control health care costs and continue to provide these services for our elderly who need them.

The CHAIRMAN. Mr. Sisisky.

STATEMENT OF REPRESENTATIVE NORMAN SISISKY

Mr. SISISKY. Thank you, Mr. Chairman.

I am going to ask unanimous consent that my prepared statement be placed in the record at this point.

The CHAIRMAN. Without objection it will be so ordered.

Mr. SISISKY. I am delighted to be here today on the 20th anniversary of Medicare and Medicaid, and also I am honored to play a part in the unfinished agenda.

The CHAIRMAN. Thank you, sir.

[The prepared written statement of Mr. Sisisky follows:]

PREPARED STATEMENT OF REPRESENTATIVE NORMAN SISISKY, 20TH ANNIVERSARY OF MEDICARE AND MEDICAID, JULY 30, 1985

Mr. Chairman, the committee approximately has called this hearing today in commemoration of the 20th Anniversary of Medicare and Medicaid. As we reflect on the successes of these programs over the past two decades, it also is important that we consider the unfinished agenda awaiting our attention.

In the period since the creation of the Medicare and Medicaid programs, we have witnessed escalating health costs and an elderly population on the rise. In the case of Medicare particularly, these trends have prompted action by Congress to curb costs and to ensure solvency at least through the end of this century. All is not resolved, however. Congress must continue searching for ways to provide solid protection for America's aged.

Because Americans on the average are living longer, it is essential that we focus on long-term for the elderly. In previous hearings, we've heard many tragic stories from families of Alzheimer's victims who are faced with financial hardships in trying to care for their loved-ones. Currently, Medicaid is the only Federal program providing financial assistance to these Alzheimer's patients, but there's a catch—personal resources must first be depleted. And even if that requirement is met, assistance is not assured—nursing beds must be available.

If Medicare and Medicaid are not available to assist these families, then where are they to turn? The Federal Government in cooperation with the states must answer that question—and soon.

So, let the celebration continue, for it is justified. But let us in the next 20 years take such action that will allow us on the 40th Anniversary of Medicare and Medicaid to express our unequivocal sense of satisfaction over a job well done.

The CHAIRMAN. Mr. Lightfoot.

STATEMENT OF REPRESENTATIVE JIM LIGHTFOOT

Mr. LIGHTFOOT. Thank you, Mr. Chairman.

I, too, would like to thank you for calling these hearings today. Representing a district that is the second-most rural in the United States and about one-quarter of the population over the age of 65, I am keenly aware of the relationship between Medicare and Medicaid and the health services rendered there as being extremely important.

And has been mentioned earlier this morning, I think as we continue down the road, we must do everything we can to work out a good teamwork effort between all the health services so that people of all ages can receive the types of medical care that they should receive.

I think it is going to be a heavy burden on our shoulders to help design a program, and I look forward to the testimony here today. I hope it will give us some insight into that.

Mr. Chairman, I am going to give you 15 seconds of that minute back.

The CHAIRMAN. Thank you very much.

I am going to skip over the next gentleman, Mr. Bonker. I am going to ask him to introduce the first witness, so I will skip him for the moment, and go to Mr. Reid.

Mr. Reid.

Mr. REID. Thank you. I have my statement for the record.

[The prepared statement of Mr. Reid follows:]

PREPARED STATEMENT OF REPRESENTATIVE HARRY REID

Mr. Chairman, I want to commend you for calling these hearings on this, the 20th anniversary of the Medicare and Medicaid programs. In particular, I want to thank you for focussing today's commemorative hearing not on the past, but on the future.

We all know what Medicare and Medicaid have done these past two decades to insure the health and welfare of America's poor, aged and infirm. But time is short for proud statements about past accomplishments. Yes, America is a more caring society today because we have these two programs. But if present trends hold, we then we are becoming less and less caring for Medicare and Medicaid recipients.

Just consider a few facts. Elderly out-of-pocket health care costs will rise twice as fast as their income between now and 1990. Sixty-three percent of elderly living alone will impoverish themselves after only 13 weeks in a nursing home. I could go on.

What we face is a crisis in health care financing. As usual, those least able to pay—the aged and poor—are finding themselves the most financially constrained. That is why I am glad we are focussing today's hearings not just on Medicare and Medicaid's first two decades, but also on these next, very crucial years.

The CHAIRMAN. Thank you, Mr. Reid.

Mr. Hughes?

STATEMENT OF REPRESENTATIVE WILLIAM J. HUGHES

Mr. HUGHES. Thank you, Mr. Chairman.

I just want to offer my sincere congratulations on the 20th anniversary of the founding of Medicare and Medicaid.

I represent southern New Jersey, which has a very high concentration of senior citizens, and their programs are extremely important to my constituency; and I will be working with my constituency and you, Mr. Chairman, in making sure that this program not only survives but is strengthened in the years ahead.

Thank you.

The CHAIRMAN. Thank you, Mr. Hughes.

The second witness was to be Senator Edward Kennedy. He sends word that he is still on the floor of the Senate on the immigration bill, which we know is important. He regrets that he will not be able to be present to give that testimony, but he is requesting that the testimony be included in the record.

Without objection, it is so ordered.

[The prepared statement of Senator Edward M. Kennedy follows:]

PREPARED STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Mr. Chairman, I am pleased to have this opportunity to testify before your committee on the 20th anniversary of Medicare and Medicaid.

The Medicaid Program has always had special meaning for me and my family. When I was first elected to the Senate in 1962, Congress was in the final stage of the long and successful battle to insure elderly Americans against the intolerable burden of serious illness. President Kennedy was proud of his role as the first President to propose Medicare: He called it the unfinished business of Social Security, and he worked for it and fought for it as Senator and as President.

With the exception of Social Security, there is no legislation that has meant more to the lives of our senior citizens than Medicare.

In the dark days before Medicare, senior citizens lived in fear that a single illness could wipe out a lifetime of savings and transform the dream of a comfortable retirement into a nightmare of poverty and despair. And far too many of our senior citizens were forced to go without the health care they desperately needed because they lacked the health insurance to pay for it.

The enactment of Medicare marked the dawning of a new day for our Nation's elderly. Since it was signed into law exactly 20 years ago today, Medicare has stood as a solemn promise by the Congress and the Federal Government, under both Republican and Democratic Administrations, that the miracles of modern medicine will not be denied our senior citizens and their golden years will be free from the fear of financial ruin because of illness.

It is sad and ironic that on the 20th anniversary of Medicare, there are those who would break that solemn promise.

The Reagan administration has consistently tried to solve the disastrous deficits that its failed fiscal policies have created at the expense of America's senior citizens and the Medicare Program.

The benefit cuts already signed into law by the President will increase Medicare premiums and cut Medicare benefits a total of $11.5 billion over the next 5 years. Additional cuts proposed by the administration in its 1986 budget would take another $15.3 billion out of the pockets of our senior citizens.

The staggering total of Reagan administration proposed and enacted benefit cuts is $26.8 billion between 1986 and 1990—an unconscionable $893 less Medicare protection for every elderly and disabled medicare beneficiary.

This administration has been extremely vocal in its opposition to tax increases—even tax increases on wealthy corporations that currently pay little or nothing. But it does not hesitate to levy this cruel additional tax on the Nation's elderly and disabled.

I am sorry to say that the budget resolution passed by its Republican senate includes the vast majority of those unfair administration cuts in Medicare benefits. When I proposed an amendment to protect our senior citizens, it was narrowly defeated.

I am proud that the Democrats in the Senate voted almost unanimously for our senior citizens in support of my amendment and I am delighted that the Democrats in this body passed a budget resolution rejecting the administration's unfair cuts in Medicare benefits. I urge the House conferees to stand firm in support of America's elderly and reject cuts in Medicare benefits as firmly as they rejected cuts in Social Security.

Those who would cut Medicare benefits either do not know or do not care how vulnerable our Nation's elderly are to the high cost of health care.

Medicare currently covers less than half of the elderly's health care cost. This year, our Nation's senior citizens will have to pay an average of about $1,700 out of their own pockets to purchase the health care they need.

That $1,700 represents more than $1 in $7 of the elderly's lhmited icomes—the same proportion they had to pay before Medicare was enacted.

The burden of health care costs on the elderly is so high for two reasons. First, there have always been significant gaps in Medicare coverage. Medicare does not cover long-term care, eye care, foot care, preventive care, or prescription drugs. Those gaps can be devastating to the elderly in need of these services.

Second, the excessive health care cost inflation of the last 25 years has harmed all Americans—but it has particularly harmed the elderly, because their need for health care is so much higher, on average, than that of other Americans.

Since 1960, the per capita cost of health care has risen 1.000 percent, four times as much as the cost of everything else in our economy.

In 1960, it cost $146 to buy health care for the average American. Today, that cost is $1,882 and still climbing.

This excessive inflation in the cost of health care threatens the very survival of the Medicare Trust Fund. By the most recent actuarial estimates, Medicare will be bankrupt by 1998 and faces a trillion dollar deficit by the year 2009. Only a comprehensive program of health care cost control such as the one Congressman Richard Gephardt and I proposed 2 years ago can assure the survival of the Medicare trust fund without adding further to the burdens of our senior citizens. Only a comprehensive cost control program can keep health care affordable for our Nation as a whole.

Today is not only the birthday of the Medicare Program, it is also the birthday of Medicaid.

Just as the enactment of Medicare meant financial security and access to health care for our senior citizens, Medicaid has been the equivalent of a health care bill of rights for poor Americans.

Prior to the enactment of Medicaid, health care was one of the many things that poor Americans had to go without. Our society paid a terrible price for that denial of health care. The price we paid could be counted in many ways—in unnecessary suffering, in premature death, in crippling illness, in lost opportunities for productive lives, and perhaps most of all, in the betrayal of those ideals for equality and compassion that have been America's promise to the world.

Medicaid was never a perfect answer to those problems. Despite enactment of Medicaid, far too many Americans remained without basic health insurance coverage and without access to health care.

But, for the 21 million poor Americans with Medicaid coverage today, Medicaid has meant the availability of mainstream medical care on the same basis as more affluent Americans. And that is something we can all be proud of.

But just as the current administration has proposed savage cuts in the Medicare benefits our senior citizens so desperately need, it has also proposed callous cuts in Medicaid. Changes in eligibility enacted in 1981 have thrown an estimated half million poor parents and children off the Medicaid rolls. Thousands more disabled Americans have been denied disability benefits and Medicaid eligibility as a result of the Reagan administration's policies.

And in the administration's 1986 budget, President Reagan proposed to cut an incredible $17 billion out of Medicaid over the next 5 years.

As in the case of Medicare, the President and his advisors either do not know or do not care about the gaps in health care faced by millions of Americans. The number of Americans without any health insurance coverage has increased 40 percent, to 35 million, just since 1977. The proportion of the poor and near poor without Medicaid has increased from 37 percent to more than half during the same period.

The shocking result is this: According to a recent study by the Robert Wood Johnson Foundation, 1 million Americans are denied health care every year because they lack the ability to pay for it. And, an additional 5 million Americans do not even seek the care they need because they know it is too expensive for them.

Mr. Chairman, I say that 6 million Americans denied essential health care every year—simply because they cannot pay for it—is 6 million too many.

Mr. Chairman, you have titled this celebration of the twentieth anniversary of Medicare and Medicaid a "bittersweet" celebration. That is an apt title. The celebration is sweet because we can take pride in the achievements of Medicare in bringing financial security and health care to our Nation's senior citizens. And, we can take pride in Medicaid's contribution of providing the health care to our Nation's poor. That is only simply justice.

But, this celebration is also bitter, because so much remains to be done.

It is bitter because the current administration persists in its callous and misguided efforts to steal the blessings of Medicare and Medicaid from the elderly, the poor, and the disabled. And, it is bitter because millions of our fellow Americans are still denied essential health care.

As we celebrate this anniversary, let us pledge that we will commit ourselves to the achievement of a healthier and more compassionate America with the same passion, the same energy, and the same unstinting demand for justice that brought us the blessings of Medicare and Medicaid 20 years ago today.

The CHAIRMAN. Mr. Bonker.

STATEMENT OF REPRESENTATIVE DON BONKER

Mr. BONKER. Mr. Chairman, I want to join the others in commending you for sponsoring this today. I think it is a timely occasion to recall 20 years ago when the Medicare bill was enacted. I was a young assistant on the Senate side, assigned to the Select Committee on Aging; and at that time Medicare, at least according to the vision of its sponsors, was to cover 100 percent of all the health-related costs of senior citizens.

But in the process compromises were made, and, as a result, the percentage of health costs to be covered under our part A and another section under part B—the result of which that senior citizens now have to purchase supplemental insurance to make up for the difference and because of other problems, the senior citizens still have to pay a sizable amount of their income on health costs.

So, while Medicare is undoubtedly very helpful in relieving seniors of the health cost burden, it still comes up way short of its original intent.

Mr. Chairman, I ask unanimous consent that the text of my full opening statement be inserted into the record at this point.

[The prepared statement of Mr. Bonker follows:]

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PREPARED STATEMENT OF REPRESENTATIVE DON BONKER

Mr. Chairman, I congratuate you for calling this hearing which provides a retrospective look at two health programs which have become the cornerstones for the physical as well as the economic well-being of older Americans. Today, we celebrate the 20th anniversary of the Medicare and Medicaid programs. In my opinion, these programs combined with the enactment of Social Security, will most certainly be recorded among the most significant legislative accomplishments established on behalf of older persons in this century.

As a Nation, we have always been committed to providing for the basic necessities of our citizens. Certainly health care must be counted among these most basic necessities. In response to the needs of our citizens, the Congress has been consistently guided by the standard that "access by all to an adequate level of care without the imposition of excessive burdens," was a desirable goal.

When the Medicare Program was enacted in 1965, the out-of-pocket health care expenses for older persons were slightly below 15 percent of their annual incomes. Considering this fact, as well as a perception that older Americans had lower earning capacity and higher medical expenses than any other adult age group, Congress acted to help ease this growing burden.

While the enactment of Medicare triggered the most rapid growth in Federal spending for the elderly, it has not effectively reduced the burden of health care costs for the elderly and their families. From a program spending $7 billion in 1970, Medicare has grown to a program with an estimated $65 billion in Federal outlays in 1985. Additionally, over the last decade, Medicare outlays have increased at an average annual rate of 18 percent—which is more than twice the rate of inflation and one-third faster than the growth in the national personal health care expenditures.

Despite this growth in annual spending, Medicare payments increasingly fail to keep pace with rising health costs. Health care expenditures not paid by Medicare have been rising steadily as a percent of elderly income. By 1981, health spending not paid by Medicare equaled 19.9 percent of the average per capital income for a person over 65—almost equal to the share of income consumed by health care spending before the enactment of medicare.

In addition, the elderly pay nearly a third of their total health care bills out-of-pocket, a percentage that has remained constant in recent years. We know that increase in health care costs continue to outstrip increases in income. As changes are enacted in Medicare that shift greater costs to Medicare beneficiaries, I fear that the propsects for continuing erosion in the value of this protection will increase.

Mr. Chairman, I think it is ironic that on this 20th anniversary of the enactment of Medicare that drastic changes have been proposed that will have the effect of shifting greater costs to medicare beneficiaries.

On this anniversary, it is important that Congress reaffirm the value of the Medicare and Medicaid programs and reassure all older Americans of our commitment to provide the protection and access to health care that they have come to expect.

Mr. BONKER. Mr. Chairman, I am privileged to welcome to the committee today a very distinguished resident and his wife of the State of Washington, Mr. and Mrs. Newton Gann of Seattle, WA.

Mr. Gann is a graduate of Texas A&M University. He has been an engineer working for the Boeing Co. for the past 32 years. He is a major in the Air Force Reserve, and has a very distinguished military career behind him.

Mr. Gann was nice enough to come here today and to be joined by his wife, Betty Gann, whom many of you have known in this committee by way of earlier testimony by a constituent who appeared before this committee last year.

We are going to hear about their individual problems associated with Alzheimer's disease. I think Mr. Gann represents what has become for many people in this country a double tragedy. That is, he believes with the noticeable trauma of a physical illness that has no apparent treatment—at least no known treatment today, and also is a person whose lifetime earnings may be wiped out with

excessive health care costs, as he continues to care for his wife. Indeed, he faces a bleak and uncertain future.

This is a situation that not only confronts Mr. Gann, but thousands of other Americans who have to deal with this double tragedy.

I want to commend the chairman for inviting Mr. and Mrs. Gann here so that they can share their story. My hope is that through their own personal experience, members of this committee will have a better sense of the double trauma that now faces many of our fellow Americans.

Mr. Gann, Mrs. Gann, on behalf of the chairman of the Select Committee on Aging, I would like to extend a very warm welcome to you.

Thank you for testifying here today.

The CHAIRMAN. Thank you, Mr. Bonker.

The Chair now recognizes Mr. Newton Gann.

STATEMENT OF NEWTON GANN, SEATTLE, WA, ACCOMPANIED BY HIS WIFE, BETTY GANN, A VICTIM OF ALZHEIMER'S DISEASE

Mr. GANN. Thank you, gentleman.

As you know, this is my wife, Betty Gann, who has been my wife for 41 years. She is the mother of our three boys, Ronald, Randall, and Steven.

Last May, at one of your committee hearings, Dr. Burton Reifler of the University of Washington Medical School, talked to you about Alzheimer's disease. He told you about a case where he diagnosed a widowed mother in her seventies as having Alzheimer's disease.

Then, a few years later, he diagnosed that mother's daughter as having Alzheimer's disease, and the daughter was in her fifties. That daughter is my wife Betty, who sits here beside me today.

After witnessing Betty's mother wither away, I am sure you can understand how heartsick we were when Dr. Reifler told us that Betty also had Alzheimer's disease.

Our plans, our dreams, our hopes, our plans for retirement, and our financial security were all shattered in one brief moment.

As we celebrate the 20th anniversary of Medicare and Medicaid, I am thankful that Betty's mother was an early recipient of Medicare/Medicaid, and received assistance for nursing home care.

But Betty, who has the same disease, is not eligible for assistance for nursing home care until all our assets are depleted.

May I repeat that? No assistance until all our assets are gone. Quite definitely, I believe that places us in the category of the "Americans at Risk" that you are talking about during this celebration.

As Betty and I face retirement, just the cost of nursing home care is bewildering, for sooner or later all Alzheimer's patients must be confined to a nursing home. The normal household does not have the facilities to provide the care that is needed.

After rearing and educating our three boys, Betty and I directed our efforts toward preparing for retirement. By hard work, pinching pennies, and with a planned savings routine, we were able to see a comfortable retirement ahead. Unfortunately, there swept

into our lives this catastrophic illness with costs so great that it was obvious our little retirement nestegg would be wiped out in no time at all.

Surely, aging was intended to be something better than that.

In the area where I live, nursing home care for ailments like Alzheimer's costs over $2,000 a month.

Mr. Chairman, that is just about the total amount of monthly income we had planned for retirement.

At these costs, the length of time our savings, and my income would hold out, can be measured in months. Our situation is not rare. It is not an isolated case. It is happening all over America.

There are several mental ailments like Alzheimer's which can, and do, happen to anyone, and the associated costs literally wipe people out financially.

Medicare and Medicaid must be broadened to help protect against the cost of nursing home care. Otherwise, couples like us will end up in poverty.

Now, I am well aware of the problems our Federal Government is facing with the budget. You could not help but be aware of that when you see all the activity taking place here in Washington, DC.

We see the mighty tug of war for every tax dollar; but we must establish a priority for that tax dollar that is based on realism and based on compassion.

Now, look, if we can find the money to recommission outmoded old battleships; and if we can find the money to build sophisticated new missiles and sink them down in antiquated holes that have been dug for 30 years; and if we can find the money to subsidize farmers to go out and grow tobacco when we know it is injurious to our health, Mr. Chairman, surely there must be a way to find the money so that Medicare and Medicaid——

Mr. GANN [continuing]. Surely there must be a way for us to find the money for Medicare and Medicaid to bear part of the staggering costs of some of these catastrophic illnesses.

After all, Mr. Chairman, the security of this Nation begins with the security of the family.

I want to thank you for the opportunity to testify today. It is a real honor to testify before a committee which can play such a predominant role in the future for aging Americans.

And may I close by making a request as respectfully and as sincerely as I know how—and that is this: Will each member of the committee join ranks and stand as one like a pillar of iron whenever anyone threatens to take away any of the Medicare and Medicaid benefits.

Thank you very much.

The CHAIRMAN. Thank you, Mr. Gann.

Mr. Gann, will you please remain seated for just a moment.

I compliment you on a fine statement. What you said with regard to our ability to find money to do things was most excellent.

It is customary that this committee ask a witness questions. In this instance, I am going to ask each member to limit their questions to only one, and that that question be directed to you and to you only.

I will start off with the first question, and that question is with regard to financial assistance.

Have you, Mr. Gann, thought of the possibility of this Nation establishing a national health plan, a plan that would actually make it possible for burdens such as yours to be lessened?

Have you given any thought to anything like that?

Mr. GANN. Mr. Chairman, when you are bewildered with a situation like this, you think of almost everything.

I truly believe that there must be a way for a couple preparing to retire and confronted with these staggering costs, for the person who is not ill to be permitted to retain some of his assets so that he may live in dignity, be independent, and therefore permit him to die in dignity.

The CHAIRMAN. Thank you, Mr. Gann.

The Chair recognizes Mr. Kolbe.

[No response.]

The CHAIRMAN. There are no questions.

The next to be recognized is—no, I am going to recognize Mr. Senior Citizen himself, Mr. Pepper.

Do you have any questions, Claude?

If he doesn't have any questions, it will be the first time since I have known him that he has not had a question to ask.

Mr. PEPPER. All I want to say is "Amen."

Mr. GANN. Thank you, sir. Thank you, sir.

The CHAIRMAN. For your testimony, Mr. Gann, "Amen" is perhaps the very right word.

Now, the next one to be recognize for a question is either Mr. McCain or Mr. Fawell on this side.

Mr. Biaggi, do you have any questions? Your time can be used for either a question or a brief statement.

STATEMENT OF REPRESENTATIVE MARIO BIAGGI

Mr. BIAGGI. I do not have any questions. I would like to assure the witness that the members of this committee have been standing together since the committee was organized, and most of the benefits that have been approved for seniors over the years have started from this committee. We respond as watchdogs. We are ever vigilant in every one of our assignment committees in the Congress insofar as the interests of the seniors of our Nation are concerned; and we could not agree with Senator Pepper's profound comment any more.

Thank you very much.

Mr. GANN. Thank you, sir.

The CHAIRMAN. Thank you, Mr. Biaggi.

Mr. Manton.

Mr. MANTON. Mr. Chairman, I do not have a question. I would just like to say that the witness' testimony was compelling, comprehensive, and I need no question to feel the impact of that statement along with, I think, everybody in this room.

Thank you for being with us.

Mr. GANN. Thank you, sir.

The CHAIRMAN. Thank you.

Ms. Meyers.

[No response.]

The CHAIRMAN. Mr. Lightfoot.

[No response.]

The CHAIRMAN. Mr. Kolbe. Any questions?

[No response.]

The CHAIRMAN. Mr. Sisisky.

[No response.]

The CHAIRMAN. Mr. Bonker.

Mr. BONKER. I want to thank you, Mr. Gann, again for being here and for your excellent testimony. I think more than anything else we heard to date, you have given this committee a personal insight to a very serious problem.

My only question here deals with Medicare. Assuming that you or your wife met the age requirement, over 65, and given the fact that Medicare only provides for care in the hospital, are you saying to the committee that the way it is presently structured that Medicare does not provide any coverage for situations involving either your mother or your wife?

Mr. GANN. For my wife—for our situation, in order to receive nursing home care, we must dispose or deplete all our assets.

Mr. BONKER. Yes; that's Medicaid, but I am talking for the moment about Medicare; and that should provide——

Mr. GANN. Medicare—Congressman, if I am correct, Medicare does not provide the care for Alzheimer's disease.

Mr. BONKER. Thank you.

The CHAIRMAN. Thank you.

Mr. Reid.

Mr. REID. Mr. Gann, could you tell the committee what assistance, if any, you received when you learned that your wife had this illness, from any State or Federal agencies, to help you understand where you were?

Mr. GANN. None, Congressman. When I learned the diagnosis, I went to Social Security to find what I might expect; and I was asked to present my financial statement, and that is when I learned that our little retirement nestegg stood in the way of any assistance and it all must be depleted before I am eligible.

Mr. REID. So, the only assistance you received in this instance was from the Social Security department?

Mr. GANN. Information, yes, sir.

Mr. REID. And were you contacted by anyone else to find out if there were any other programs available?

Mr. GANN. Well, the local programs in the city. We have an Alzheimer's assist group. I learned that through the University of Washington Medical School, which treated my wife and her mother.

Mr. REID. Was that of any assistance to you?

Mr. GANN. Oh, yes, yes.

And I was hoping that one of you gentlemen would ask about the research program. We must listen to the medical community in this regard. Research—research—research on this problem is the answer—research, in the units in the research center like we have at the University of Washington for Alzheimer's.

There must be research. That is the only hope for the future.

Mr. REID. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Reid.

Mr. Volkmer?

Mr. VOLKMER. Yes, I would like to also thank Mr. Gann. At this point I would like to ask if not only your savings but are you also proposing that you would have to sell your house and the car?

Mr. GANN. All available assets, sir.

Mr. VOLKMER. Including your home?

Mr. GANN. All——

Mr. VOLKMER. That has also happened to a neighbor of mine whose husband had a stroke. He is not able to care for himself, and I think he went into a nursing home. Just the first of this month, she had to make the choice of selling her home that they had had or depleting her savings, or else take him out of the nursing home and try to take care of him herself. She does not have the assets to take care of him.

Mr. GANN. Yes, sir.

Mr. VOLKMER. It is a similar situation, and I agree with you. We really have to find a way to take care of this situation.

Mr. GANN. Amen, sir.

Thank you, sir.

The CHAIRMAN. Thank you, Mr. Gann.

Again, I would like to compliment you for very excellent testimony. Yours is one of millions of cases, similar cases throughout the country, but your testimony has highlighted the problem.

You spoke on behalf of millions of people. I sincerely hope that Members of Congress have listened, and that we in this very excellent debating society finally run out of words and take some action, and do something about the problem that you have brought to our attention this morning.

Thank you very much.

Mr. GANN. Thank you, sir.

The CHAIRMAN. Ladies and gentlemen, just a few days ago, we learned that Dr. Carolyne Davis would be leaving the Administration on August 9.

Dr. Davis is the longest serving Administrator of the Health Care Financing Administration.

I am sure that you feel that your term of Government service has been somewhat bittersweet, which is the word that we coined for today's activities.

Regardless of what the people at the other end of Pennsylvania Avenue may feel, I want to assure you, Dr. Davis, that we deeply appreciate your perseverance. We deeply appreciate your willingness to take on those who never appreciate what Medicare/Medicaid means to someone who is ill, and is old, and disabled, and poor.

Yes, Dr. Davis, you have done a good job, and I thank you for it.

Just before you start, I would like to recognize the gentleman from New York, Mr. Biaggi, who would like to address a few words to you.

Mr. Biaggi.

Mr. BIAGGI. Thank you very much, Mr. Chairman.

Currently, I am presiding as chair in another committee, but I simply had to take this occasion to listen, for a brief spell before I returned, to Dr. Carolyne Davis, on her last appearance before this committee, in her present capacity. One never knows about the future.

We wish her well in her new undertaking, and I am sure the skills she has demonstrated here in Washington as a very skillful and expert administrator with thoughtful input into the whole legislative process with a kind of a sterling performance that is generally unmatched.

And although we have differed on occasion, as we struggled with difficult and challenging problems, in the end, we have mutual respect for each other's attitudes and ultimate commitment; but in the end given all the parameters of restraint that each of us has sometimes been confronted with, the principal concern would be that of the elderly of our Nation.

Let me say that I regret it is your last appearance, but 4½ years is a long, long time on the Hill; and the fact that you survived is again another demonstration of your many and varied abilities.

We wish you well, and godspeed.

Dr. DAVIS. Thank you, Mr. Rinaldo and Mr. Chairman.

The CHAIRMAN. Dr. Davis, will you please proceed, in any manner that you may desire.

STATEMENT OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY MARTIN L. KAPPERT, ACTING ASSOCIATE ADMINISTRATOR FOR OPERATIONS; AND ROBERT A. STREIMER, ACTING DIRECTOR, BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE

Dr. DAVIS. Thank you very much.

I am very pleased to be here today on this 20th anniversary of the enactment of Medicare and Medicaid, to reflect on the strides that we have made in improving the health care delivery systems for our elderly during the program's evolution.

Joining me this morning, on my right, is Mr. Marty Kappert, who is the Acting Associate Administrator for Operations, and he has actually had a history of being with the program throughout the entire 20 years. In fact, he was one of the original task force planning members for the initial planning for Medicare, back in 1965.

And, on my left, is Mr. Robert Streimer, who is the Acting Director of the Bureau of Reimbursement, Eligibility, and Coverage, and 18 years with the program.

As you can see, both of these gentlemen are part of our top career management team and are indeed veterans in working with the programs.

Medicare and Medicaid have certainly been successful in improving access to health care services; and, along with that success, however, has come an extraordinary, unnecessary health care inflation, which has indeed necessitated our recent efforts to ensure the financial viability of both Medicare and Medicaid, and yet still continue to provide quality of care.

In fact, Mr. Chairman, it is important to recognize that this very year, Medicare and Medicaid, the Federal share only of Medicaid, along with Medicare, we will be spending $97 billion for benefits to the poor and the elderly.

And that is up from last year's $84 billion. To translate that to numbers we can all understand better, what that really means is that the Federal share of Medicaid and Medicare, standing together will consume $11 million an hour every hour, day or night, $11 million an hour we are spending on the benefits for health care for our poor and elderly.

And that is up from last year's $9.6 million an hour. During this 20th anniversary year, 30 million of our beneficiaries will receive some $70 billion in benefits through the Medicare program itself, which is spending at the rate of $8.5 million an hour this year.

And, today, our beneficiaries receive benefits beyond the contributions that they make, into the Hospital Insurance Trust Fund.

If you observe chart 1, you will indicate that the individuals, if they are to become eligible for Medicare, let's say, in 1983, the average contribution that would be made during their years of employment would be approximately $2,690; and the maximum contribution would have been $4,680.

However, we estimate that they will be receiving in benefit returns throughout their lifetime $34,000 in benefits if they are a female and $28,000 in benefits if they are a male.

That is at a significant rate of spending then for every $1 that has been contributed into the trust fund.

If one is a female, one would be getting a return of $13 for each dollar placed into the trust fund.

The real value of the Medicare benefits for an aged person has been growing at the rate of about 1.3 percent per year.

During the last 3 years, Congress and the administration have put in place, I think, the most significant changes in the program since Medicare was enacted.

Since the Medicare program has two-thirds of its outlays going to hospital expenditures, it was the first part of the program that we looked at in terms of our reimbursement reform activities.

And under prospective payment system, the open-ended cost base reimbursement system was abandoned in favor of payment on a per case, known as the diagnosis related groups.

After a history of annual increases and admissions, we also saw in fiscal year 1984 the first year in which the actual number of admissions declined. They declined not only in our Medicare beneficiaries, but across the Nation in all age levels.

Since Congress has realized that in addition to new incentives with the efficient use of resources, there is also a need to increase the safeguards on the quality of the services provided.

Peer review organizations were tasked, not only with reducing unnecessary admissions but also and more importantly with looking up specific objectives for assuring and improving the quality of care that is rendered.

As a result, too, of the Tax Equity and Fiscal Responsibility Act of 1982, we are now paying our health maintenance organizations on a capitated basis.

That's also based on a prospective fee. We now have approximately 54 risk contracts that are enrolling close to 400,000 Medicare beneficiaries, and we anticipate growth is going to be in excess of 5 percent a month, so that we expect a substantial interest and increase in growth in the new risk contracts of the HMO program.

For today, HMO's are indeed providing beneficiaries not only with the usual Medicare benefits, but with additional benefits, at no additional out-of-pocket cost.

For example, there is one HMO in California that provides free dental care and eyeglass care, in addition to their usual Medicare benefit package.

As you know, this past October, we also implemented the participating physician program, and in the participating physicians, they are the ones who have agreed to accept the Medicare as payment, as full payment—or, in other words, to accept assignment on all Medicare claims for a 1-year period.

We also published directories with the lists of all physicians who did participate in the program; and by choosing participating physicians, the beneficiaries can avoid the expenses incurred from extra billing liability on unassigned claims.

Although we had only 30 percent of the physicians nationwide signing up to accept assignment all of the time, I think it is important to recognize that over the last several months, since last October, the rate of increased assignment has been significant.

We now find that in the month of May, we have almost 70 percent of all of our claims being accepted for payment under assignment, and that is across the board.

The Medicaid program is, as you know, the largest public financer of health care for the Nation's poor, spending some $34 billion in 1984, for over 21 million recipients.

This program now represents 11 cents out of every dollar spent by Medicare on their medical care, and, as chart 2 will show you, in the 1984 personal expenditures care, we find that 18 percent is paid from Medicare, and 11 percent from Medicaid.

The Medicaid Program, of course, was designed as a program for certain groups of the low-income people. Unlike the Medicare Program, where two-thirds of the dollars are spent on the acute care portion, the Medicaid Program spends its largest proportion on the program funds for the nursing home component.

As you will see in this chart, some 44 percent of all Medicaid expenditures go to pay for nursing home care.

Since 1980, there have been four major pieces of legislation that have impacted on the Medicaid Program, with the general theme of increasing State flexibility and cost containment.

States are beginning to implement new prospective hospital reimbursement systems that are significantly improving the hospital's efficiency, thus reducing Medicaid costs and giving them additional dollars to use in other areas.

Likewise the States have been encouraged to experiment with a variety of innovative health care delivery systems, such as the home and community-based service program, where they can pay for care for individuals in the home rather than institutionalizing them.

Medicare and Medicaid combined then will finance the health care needs in terms of all national health expenditures about 28 percent. The Medicare and Medicaid programs alone however, I believe, do coincide also with the Nation's total aggressive and successful efforts at increasing access to medical services for the elderly and the poor.

But we still face significant challenges and difficult choices in the future. Our demographic projections show that the number of the elderly nationwide will more than double by the year 2030, and that's clearly going to place enormous pressures on our health care programs.

So, indeed, we must begin today to explore the types of financial arrangements which can make the provisions of care fiscally possible in the year 2030.

In Medicare, we are exploring various ways to bring more of our services under the discipline of capitation, and you heard of our encouraging the growth of the competitive medical plans, and the HMO's, or health maintenance organizations.

And in Medicaid we are continuing to grant waivers; we are looking at home and community-based services and exploring other alternatives in the provision of long-term care services, as well as encouraging the growth of capitated systems of delivery of care.

It is important, too, to recognize that in the Medicare Program, although we have shored up the system, for the short term, and it is fiscally solid until 1998, we still have some long-range problems to ensure its total fiscal solvency.

In order to guarantee its solvency for the full 25 years, we must either reduce our expenditures on the average by about 19 percent, or increase the revenues coming into that fund by 24 percent in order to guarantee its total fiscal solvency over the long-range life of the program.

We believe that we must continue to restructure the delivery system, to refine our reimbursement payment mechanisms to our providers in order to promote the continued delivery of high-quality health care services for all of our beneficiaries, and we are committed in this administration to continuing to preserve and to protect that course in order to strengthen the long-term solvency of both programs.

Mr. Chairman, I have had the unique privilege of being the caretaker of Medicare and Medicaid over the past 4½ years, which is roughly equivalent to almost a quarter of the time of the program's being in existence; and I am very pleased to have had the privilege to play a role in strengthening the financial basis of these programs.

I believe that they will now be better able to face the challenges ahead. I want to thank Congress for the leadership that it has provided, working with the Administration to make these entitlement changes that have made the overall health care system more solid into the future.

And I thank you for the opportunity to join with you on this 20th anniversary.

I will be happy to answer any questions.

[The prepared statement of Dr. Davis follows:]

PREPARED STATEMENT OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

I am pleased to be here today on this 20th anniversary of the enactment of Medicare and Medicaid to share with you where I believe the programs are today and some of the challenges we face in the future.

No one can doubt that July 30, 1965 was a bright day in the history of this country. With a stroke of a pen, the resources of the greatest health care system in the

world became available to senior citizens and to many of the disadvantaged. As a result, the quality of their lives was dramatically improved, access was opened to some for whom it had previously been denied and the threat of financial ruin due to serious illness was dramatically reduced. As the Administrator of this agency, I am well aware of the fact that both programs have limitations. However, I have seen during the past four and half years, the most dramatic reforms to the program since their inception. Today is a grand opportunity to reflect upon the strides made in improving health care access and delivery for our 50 million beneficiaries and to note our recent accomplishments which serve to accent the positive changes in the programs' evolution.

Medicare and Medicaid have been successful in improving access to health care services. Along with this success, however, came extraordinary and unnecessary health care inflation which necessitated our recent efforts to ensure the financial viability of Medicare and Medicaid while still providing quality care. The choices that we've had to make have not been easy, but today Medicare and Medicaid are stronger and better equipped to face the next twenty years.

MEDICARE

The Medicare program has achieved its initial goal of providing access to quality health care services to our senior citizens. During this 20th anniversary year, 30 million beneficiaries will receive $70 billion in benefits through Part A and Part B. Almost all of the hospitals in this country and 90 percent of physicians will treat at least one Medicare patient.

While 53 percent of the payments for health care for the aged were financed through premiums from beneficiaries in the year Medicare was enacted, in 1984 premiums from beneficiaries had to cover 25 percent of costs. In examining these out-of-pocket expenditures, it is important to keep in perspective the source of funding for these programs.

Today's Medicare beneficiaries will receive benefits far beyond the contribution they made into the Hospital Insurance Trust fund. For individuals who became eligible for Medicare in 1983, the average contribution made during their years of employment, even with accrued interest, is $2,690. However, we estimate they will receive, $34 thousand in benefits if they are female and $28 thousand if they are male. That's anywhere from 10 to 12.5 times their contributions. Even under Part B, enrollees receive four dollars in benefits for every one dollar in premiums they pay.

Since 1965, there have been many changes made to the Medicare program. In 1972, the disabled were granted eligibility, as were individuals suffering from end stage renal disease. I believe, however, that within the past three years Congress has put in place the most significant changes in the program since Medicare was enacted. These changes have:

Strengthened the financial status of the program through introducing incentives for efficiency,

Increased safeguards over the quality of care,

Broadened beneficiary choice of providers, and

Increased the financial protection provided by the benefit package.

STRENGTHENED FINANCIAL STATUS OF PROGRAM

In the 1982 Trustee's report our actuaries projected that the Hospital Insurance Trust Fund would be depleted during 1987. In the most recent report, the estimate was changed to 1998. This turn around was in the large part due to both the drop in overall inflation rate in the economy and the implementation of the prospective payment system (PPS) for hospitals. Under PPS, open-ended, cost-based reimbursement was abandoned in favor of a flat per case payment based on DRG's. Cost based reimbursement had been one of the major forces behind the high rates of increase experienced by Part A. From the beginning of the program up to the introduction of PPS, Part A outlays grew at an annual rate greater than 18 percent. Even with increases in tax and wage base from those initially set in 1965, the program still was on the brink of insolvency.

After an uninterrupted history of annual increases in admissions, FY 1984, the first year of PPS, was also the first year in which admissions actually declined. Length of stay which had previously been declining at a average annual rate of two-tenths of one day per year, dropped by nine-tenths of one year. As a result of both these events, Part A outlays for inpatient hospital services grew by only 7 percent. That's the smallest increase in outlays since FY 1970.

The PPS system also produced dividends on the Part B side. The reduction in admissions and length of stay resulted in lower outlays for inpatient hospital physi-

cian services. This, combined with the fee freeze mandated by the Deficit Reduction Act of 1984, reduced the increase in Part B outlays to half what it had been over the previous ten years.

A lesser known story in our efforts to control program costs has been the progress that has been achieved in reducing administrative overhead. During FY 1967, we spent 4.3 percent of program dollars on administrative expenses. Due to both the steady increases in productivity gained through application of computer technologies and the improved management of our contracts, we spent 2.5 percent in FY 1984.

INCREASED SAFEGUARDS OVER QUALITY OF CARE

Congress also realized that in addition to new incentives for the efficient use of resources there was also a need to increase safeguards on the quality of the services provided. In response to these concerns, Congress enacted the Peer Review Organization (PRO) program. The PROs are tasked, not only with reducing unnecessary admissions, but also with specific objectives for assuring the quality of care rendered. The areas of quality review include: Reducing unnecessary hospital readmissions resulting from poor care during prior admissions; assuring completeness of treatement; reducing unnecessary surgery or other invasive procedures; and reducing avoidable postoperative complication.

The PRO program is in place and working. We believe that it is assuring quality of care under PPS.

BROADENED BENEFICIARY CHOICE

During the past few years we have expanded beneficiary choice in regard to the setting in which Medicare benefits are received. Although HMOs became providers under Medicare in 1972, the primary method of reimbursement was on the basis of costs. This reimbursement method did not allow for the full utilization of the financial incentives normally present in capitated arrangements, that is, to provide quality but cost-effective services to enrollees within a fixed payment amount.

As a result of the Tax Equity and Fiscal Responsibility Act of 1982, we are now paying HMOs on a capitated basis, based on a prospective fee which utilizes the adjusted average per capita cost (AAPCC). There are now 54 TEFRA risk contracts enrolling 343,000 Medicare beneficiaries. Growth is currently in excess of 5 percent per month and we expect substantial increase growth as new contracts are negotiated.

HMOs today are providing beneficiaries with additional benefits at no additional out-of-pocket cost. For example, there is an HMO in California that provides free dental and eye care in addition to the Medicare benefit package. Other HMOs are providing a much richer benefit package for a relatively small additional premium. For example, an HMO in Minnesota provides prescription drugs, dental care, eye care, hearing exams, immunizations, preventitive services, routine foot care and unlimited hospital days for an additional monthly premium of $21.70.

In addition to HMOs, in recent years beneficiary choice was expanded in another very significant way. The Hospice benefit provides an alternative method of care to the terminally ill that allows them to continue their lives with as little disruption as possible. Beneficiaries now have the choice of receiving traditional services or hospice care which emphasizes supportive services, such as home care and pain control. Today 8,000 beneficiaries are exercising this very personal option.

INCREASED FINANCIAL PROTECTION

This past October we implemented the participating physician program. Participating physicians are those providers who agree to accept Medicare's payment as payment in full, that is, to accept assignment, on all Medicare claims for a one year period. This program provides beneficiaries an opportunity to reduce out-of-pocket expense. By choosing a participating physician, beneficiaries can avoid the expense incurred from the extra billing liability on unassigned claims.

The participating physician program has played an important role in increasing assignment rates. In the January-March quarter, 66.8 percent of program payments were accepted on assignment. This was an increase of 17.6 percent over the same quarter in the previous year. This increase compares with the average annual increase of 2.7 percent experienced during the five year period prior to the beginning of the participating physician program. In the month of May the claims assignment rate was 69.3 percent.

The increase in assignment rates is across the board. All carriers experienced an increase in the January-March quarter. Half had an increase of 20 percent or greater. Four had an increase of more than fifty percent.

On this 20th anniversary, we still face many challenges in Medicare; physician reimbursement reform and further refinements of PPS. But the program is in a much better position to meet these challenges as a result of the combined effort of Congress and this Administration.

MEDICAID

The Medicaid program was enacted in 1965 to fill the gaps in Medicare coverage for the indigent elderly and to pay the costs of medical care for other poor persons.

Medicaid is the largest public financier of health care for the nation's poor, spending $34 billion in FY 1984 for over 21 million recipients. This now represents eleven cents out of every dollar spent by Americans on their medical care.

In contrast to the Medicare program, which is administered by the Federal government and includes uniform nationwide eligibility criteria and benefits, Medicaid is financed jointly by the Federal and State Governments and designed and managed by the States. Historically, States have had great discretion over the type of medical benefit package they will provide to their eligible populations as well as the definition of who will be covered as a Medicaid recipient.

The Medicaid program provides health care for certain groups of low income people, primarily those already receiving cash assistance under the Aid to Families with Dependent Children (AFDC) and the Supplemental Security Income (SSI) programs. This generally includes members of families with dependent children and the aged, blind, and disabled. In addition, States may choose to pay for the care of those indivuduals who are "medically needy"—that is, families who have enough income to pay for their basic living expenses but not enough to pay for their medical care. Currently, 20 States and territories cover only those individuals receiving cash assistance, and 34 States and territories cover both cash assistance and medically needy recipients.

States must provide nine basic services to most program beneficiaries. They are: impatient and outpatient hospital services, rural health clinic services, laboratory and x-ray services, skilled nursing facility and home health services for individuals over age 20. Early and Periodic Screening, Diagnosis, and treatment (EPSDT) services for children, family planning services and supplies, nurse midwife services, and physician services. However, in addition to these nine, States also can provide and receive Federal matching for up to 25 optional medical services, such as prescription drugs, eyeglasses, and dental care.

Unlike Medicare, which spends the largest proportion of program funds on hospital care, Medicaid spends 43.8 percent on nursing home care. In part, this occurs because Medicare covers most inpatient hospital service for the aged poor, Even so, inpatient hospital costs rank second with 26.2 percent of total program expenditures, followed by physician services at 6.5 percent of program funds. The elderly receive 37 percent of all Medicaid expenditures, mostly for long term nursing home services. The disabled receive approximately 35 percent of all expenditures and AFDC families receive nearly 25 percent of all program funds.

TRENDS TO 1980

Medicaid expenditure trends from 1965 until the present Administration have been marked by phenomenal growth. Only now are the rates of growth in program outlays beginning to stabilize with the introduction of recent legislative initiatives such as the hospital prospective payment system and alternative long term care arrangements.

Between 1965 and 1984, there were four major periods or eras of Medicaid expenditure growth. The reasons for this growth differed significantly for each period.

The period from 1965 to 1971 saw phenomenal growth, an average 31 percent per year, due to start-up costs of the program.

The next major era in Medicaid history, 1972–1975, continued the growth pattern at 21 percent per year, due largely to the addition of new institutional services for the mentally retarded.

The period between 1976 and 1980 saw a significant drop in the expenditure growth rate to 15 percent per year. This was the first time that the number of recipients declined and medical price inflation began to emerge as a major factor in Medicaid expenditure growth.

The annual growth in Medicaid expenditures has declined from 15 percent for the period 1976–1980, to 10.1 percent for 1980–1984. The growth rate was only 5.8 per-

cent between 1983–1984, well below the 9 percent growth rate in total national health expenditures for the same year. This dramatic change can be attributed partly to Congressionally-mandated decreases in Federal reimbursement and partly to State-initiated program changes.

RECENT LEGISLATIVE CHANGES 1981–1984

Since 1980, four major pieces of legislation have affected the Medicaid program. They were: The Omnibus Reconciliation Act of 1980 (ORA) P.L. 96–499; the Omnibus Budget Reconciliation Act of 1981 (OBRA) P.L. 97–35; the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) P.L. 97–248; and the Deficit Reduction Act of 1984 (DRA) P.L. 98–369.

Two general themes of these Acts were: (1) increased State flexibility in program design, and (2) cost containment.

In 1981, OBRA reduced the Federal contribution to Medicaid spending while greatly increasing the administrative flexibility of the States. Federal reductions provided an incentive for the States to take certain actions to reduce program expenditures.

For example, States began to implement new, prospective hospital reimbursement methods that significantly improved hospital efficiency, thus, reducing Medicaid costs. To date, 26 States have instituted these new methodologies. Between 1980 and 1984, the rise in outlays for hospital inpatient services declined from 12.2 percent to 1.6 percent.

States also were given the opportunity to experiment with a variety of innovative health care delivery systems that would fulfill two objectives:

(1) Shift the emphasis of the program away from more costly institutional long term services to community-based long term care; and

(2) Redirect recipients to more efficient, cost-effective providers of service.

As of June 30, 1985, 47 States have requested 178 waivers to provide home and community-based services to individuals who would otherwise be placed in a nursing home. Forty-six States now have 107 approved home and community-based waivers. Twenty-eight States have requested 116 waivers to pursue cost-savings associated with more efficient service programs, like primary care case manages. Eighteen States now have 54 approved freedom of choice waivers. These two programs seem to be helping to hold down costs. Rates of increase in nursing home expenditures have dropped from 18.4 percent per year for 1973–1980 to nearly 11 percent per year in 1980–1984.

We believe these changes substantially improve the Medicaid program. These new health delivery initiatives and their impressive success thus far are the crucial prerequisites to a future program that will care for this nation's poor without enervating the fiscal resources of our Federal, State, and local governments.

CONCLUSION

The programs that were born 20 years ago, today eclipse all other third party payors. Medicare and Medicaid combined finance 27 percent of all national health expenditures, 37 percent of all hospital care, 45 percent of all nursing home care and 24 percent of physician services. But the programs have also had an impact on people's lives that is as large as the magnitude of the services financed.

Before Medicare and Medicaid, poor elderly people seeking hospital care received substantially less care than the middle class elderly. By the mid-1970's, this inequity had been erased.

In 1964, the year before Medicaid's enactment, the nonpoor saw physicians 20 percent more often than the poor. This disparity had been eliminated by 1974.

There have been significant reductions in death rates and increases in life expectancy since 1965 which are linked to increased use of medical services.

Medicare and Medicaid alone cannot claim direct credit for all of these impressive improvements. However, these improvements do coincide with the nation's most aggressive and successful effort to increase access to medical services for the elderly and the poor.

Although much has been accomplished during the past twenty years, we still face significant challenges and difficult choices in the future. Demographic projections show that the number of elderly nationwide will more than double by 2030, at which time they will account for one-fifth of the U.S. population. Clearly, this will place enormous pressures on our health care programs. We must begin today to explore the types of financial arrangements which will make the provision of care fiscally possible in the year 2030.

In Medicare we are exploring various ways to bring more of our services under the discipline of capitation. Over the next few years, in addition to encouraging the growth of HMOs and CMPs, we will be experimenting with new models of capitation, such as putting an insurance entity at risk for the provision of care in a geographic area. This entity, while providing the traditional Medicare package as an option, would also provide alternative plans that would utilize preferred provider organizations.

In Medicaid, we are continuing to grant waivers under the home and community based waiver authority to explore alternatives to the provision of long-term care services in institutional settings. As a result of this program we are able to encourage creative approaches, that may hold the key to the provision of long term care services over the next twenty years. We are also conducting research on capitated Social Health Maintenance Organizations (S/HMOs) for our frail elderly, and we are exploring with the National Association of Insurance Commissioners ways to encourage private long-term care insurance.

I have had the unique privilege of being the caretaker of Medicare and Medicaid for the past four and one half years. I am pleased to have been able to play a role in strengthening the financial basis of these programs so that they will be better able to face the challenges ahead. The leadership that the Congress and the Administration have taken in making these entitlement changes has made the overall health care system more competitive. This competition will increase the efficiency of Medicare's and Medicaid's reimbursement systems, increase the opportunity for beneficiaries to get more for their health care dollar and increase access and choice as more providers and new types of providers enter the market place. It is this increased competition, along with strengthened quality assurance activities that will allow us to continue to provide our beneficiaries access to the best health care system in the world.

Thank you for the opportunity to join with you on this 20th anniversary. I would be happy to respond to any questions that you may have.

The CHAIRMAN. Dr. Davis, I would like to thank you for your testimony.

At this time, I would like to recognize Mr. Rinaldo, who is the ranking minority member of this committee. After he has questioned the witness, I would like to ask one or two questions. Then, we will recognize the other member of the committee.

Mr. Rinaldo is now recognized.

Mr. RINALDO. Thank you very much, Mr. Chairman.

I understand the opening statement I had has already been included in the record, but at this moment I would just like to thank Dr. Davis for her testimony.

During her tenure, health care inflation has been reduced from double digit levels.

She was instrumental in pushing through DRG's, and I think in the final analysis there is nothing more important than maintaining health care benefits and Medicare systems and controlling health care costs. I think that is essential. That is the only way we can continue these programs, and continue them in a manner that they are the greatest benefit to the people who need them, deserve them, and are entitled to them.

She has been a conscientious, dedicated administrator, and while I, as an individual, did not agree with her 100 percent in every area, the important thing, Mr. Chairman, is that when we did not agree she has always tried to work out any problem areas, and I want to take this opportunity before I ask her a question to certainly wish her well and the best of everything in the years ahead.

Dr. DAVIS. Thank you very much, Congressman Rinaldo.

Mr. RINALDO. You heard the testimony of Mr. Gann whose wife has Alzheimer's disease.

Can you tell the committee why, now that we know more than we did not too many years ago about Alzheimer's, why does not Medicare reimburse for Alzheimer's disease?

Dr. DAVIS. Well, yes. I did hear the testimony.

We recently found that some of the physicians' charges were being erroneously classified.

There is a reduction in the payment here when they are caring for a patient with Alzheimer's disease, since it is classified as a neurological problem.

I think the bigger question that the gentleman was referring to was the whole issue of who will pay for the care in the nursing home when one does need that type of care services.

We have been concerned in the Department, as you well know. Secretary Heckler has been well recognized as being very concerned about the problem of Alzheimer's disease. She has called for several high-level conferences of the research community looking into the problems.

Dollars have been allocated and reallocated, shifted from other funds into support for the research and development program, and we have a demonstration program ourselves in the area of the respite care, which is—respite care is when one can give alternative sources of support to the family for part of the time in order to allow them, if you will, "breathing time," to have some relaxed time before they take up the total 24-hour care of the individual again.

I do note that we in the Health Care Financing Administration are supporting a demonstration at the University of Washington in their Institute of Aging; and I have a suspicion that it is part of that program through which they were receiving some guidance and counseling.

I sincerely hope it was since that is the purpose of that program as a demonstration program to allow us to learn what we need to learn whether it is appropriate to really endorse further funding in this particular area.

Mr. RINALDO. That demonstration program then is not for—is it limited to respite care?

Dr. DAVIS. Sorry, it is limited to respite care and to education of the family caregivers themselves. We believe that it is important for us to educate the family members who are going to be involved in the care itself as to the entire spectrum of services that are available.

So, it is a two-part program.

Mr. RINALDO. At the conclusion of that demonstration program will the Health Care Financing Administration be in a position to evaluate the feasibility of reimbursing for this disease?

Dr. DAVIS. Yes, sir; we expect that report—that was funded in 1983, and we expect the final report in in about middle of the year 1986.

Mr. RINALDO. OK. Thank you very much, Dr. Davis.

Mr. Chairman, thank you. I have no further questions.

The CHAIRMAN. Thank you, Mr. Rinaldo.

Dr. Davis, you are a person with great experience in this field; and while we hate to lose you, I still feel that we are not going to lose that background you have.

I seem to feel that your interests in the elderly, and the oppressed and the poor will continue no matter where you go.

I am sure that you have personal ideas as to what can be done about improving Medicaid, and I am sure that you have ideas about what can be done to improve part B of Medicare, and in what way we can do something about the overall system, ways for DRG's to be improved.

I realize that to ask these questions now and to put them down on the record will take quite a long time.

So this is my question. Would you be willing to submit to the committee your personal views as to how these programs can be administered more effectively, whether it be now or sometime in the future?

Do you think that is possible, Dr. Davis?

Dr. DAVIS. Yes, Mr. Chairman.

I would be happy to do that, and you are quite right. Coming out of the field of nursing, I have been involved with the delivery of services to not only the elderly and the poor, but to all individuals throughout my lifetime, and I will continue to have a keen interest in these programs. You could not help but have when you have invested 4½ years of long, hard, arduous time within the program.

But I leave confident of the fact that the career people who are within the Agency are very competent and knowledgeable and they will be able to continue to advance the programs.

However, I would be delighted to submit for the record—if you would pardon me, I would like a couple of weeks vacation before I get started on that specific responsibility however.

The CHAIRMAN. What this committee needs is advice. We are not a legislative committee. We are a fact-finding committee, and we are just looking for answers to these important questions.

How could we improve the system?

What can we do to make the program available to more people?

These are my questions that have some answers somewhere. I would like to have a very concise and logical explanation as to how you think this can be accomplished.

What is it that this committee can recommend to the Congress of the United States that will make more sense than what we see at the present time?

We all agree that Medicare and Medicaid are good, but not good enough. The testimony that we heard today in this committee—and on other occasions certainly tells the committee that we are just not doing enough for those in need in this country.

And the next question is what can the Congress do?

So, these are some of the questions that I hope that your communication to me will address.

Dr. DAVIS. I certainly would be happy to.

I would like to point out that the committee has this morning explored their concerns in relationship to long-term care area. We too have had some concerns. In fact, our Agency hosted a conference last Spring—February of 1984—trying to identify problems and possible solutions, looking at the whole area of long-term care.

We devote approximately one-third of our research budget to looking at the various issues as they relate to long-term care areas.

And most recently I have assigned a staff person within the Agency who is working with the National Association of Insurance, individuals who are looking at a study of the potential for something on long-term care insurance.

So, we are concerned, and I will stand ready to help in any way that I can.

The CHAIRMAN. My particular problem has been that there are people in the Agency that are concerned and knowledgeable but they refrain from making recommendations that may be against certain administration policy.

These are people that, in my opinion, can make recommendations once they are outside the administration, and not within the administration. Not only this administration, but any administration. I am not being critical of any particular Administration at this point.

Dr. DAVIS. I think what we have been trying to do is to arrive at what seems to be a blend of responsibilities from both the private sector and the public; and to do that we really need to have the results of some of our demonstration efforts, some of which is just now coming in on long-term care channeling demonstrations as being completed with big departmental-wide efforts.

And, as I indicated earlier, our respite demonstration will certainly give us some additional clue, but I certainly will be happy to show whatever knowledge I have.

The CHAIRMAN. Thank you, Dr. Davis; and I am sorry I am going to have to leave. My bill is on the floor. This bill was started last Friday. Unfortunately, we did not finish and now we have to go back and finish that bill.

And therefore I ask the gentleman from Virginia, Mr. Sisisky, to take over and the hearing will continue as soon as he gets to this chair.

[Pause.]

Mr. SISISKY [presiding]. Mr. McCain.

Mr. MCCAIN. Thank you, Mr. Chairman.

Dr. Davis, I want to express our appreciation for your dedicated service during the last 4½ years in what has been a very difficult job. We thank you for your service here with a great deal of pride and the accomplishments you have made.

I believe that we can look with justifiable pride at the decreases in expenditures or the decrease in the real growth of expenditures for hospitalization mentioned in your statement. The hospital insurance trust fund will now be solvent until 1988, because of a number of measures we have taken.

We are struggling right along with the DRG expenses. We can look with pride at our accomplishments in DRGs, but at the same time there have been and continue to be increasing reports of individuals who are discharged without proper care, sent from one place to another without proper treatment.

In your statement you mention the Peer Review Organization Program which I am sure has been very valuable.

However, it does not seem to address the problem. I think—and it is my opinion, and I would like your comment on this—that we should look at the fact that a 65-year-old man who needs a hernia

operation entails a different level of care than a 90-year-old man who is suffering with the same ailment.

I would be very interested in your comments on that. Do you have any plans to further refine the DRG system to take into account the physical condition and age of the patient involved in the program?

Dr. DAVIS. Yes, sir.

To address your beginning comments related to the fiscal solvency, it is indeed too true that the initiation of the DRG system is clearly one of the avenues—while I would love to take credit for rescuing the entire system, I think it is broader than that. We did indeed have an upturn in the economy. With more people working, there were more dollars coming into the trust fund also, and additionally we were successful in finding alternative ways of delivering the care rather than in the hospital, in other words, delivering some of the care in more cost-effective manners through ambulatory surgical centers, and that, too, of course, diverted some of the funds.

So, I think it is a combination of all those that did give us the delay in the solvency of the trust fund.

I have a varied concern to guarantee the quality of care. We have asked our Peer Review Organizations to vigorously review. They are reviewing approximately one-third of all of the hospital admissions now, and they have the ability to target selected areas where they have problems and to intensify their review, if they think there are problems, they have been told to, not only intensify the review but in many cases will do a concurrent review for the quality of care even before they are discharged, and they can actually impose sanctions; and in a few cases—not very many, I think six or seven cases—they have moved to impose an actual penalty or sanction on the individual hospital or physician.

But on the whole I think that our providers of care are very conscious of the need for providing high quality care and are truly at work trying to do so.

We are refining the DRG system. We have been working to perfect a new, what we call, a new area wage index because it was pointed out to us that some of the rural hospitals had a lot of part-time help, and that was not recognized in the previous index. So, this year, we did refine that.

That does mean a shifting of some payments between the parts of the hospital.

We have also funded several kinds of research programs looking at further refinements in the DRG system. We speak of the differentiation in terms of what we refer to as the "severity" of illness within a DRG. We are funding six projects. My report is due to Congress this coming December, that will speak to which one of those we think will be most appropriate to use to further refinement of that system.

It is true that at the moment the DRG system does allow for recognition of some of the differences in care that are demanded. For example, those individuals who do have additional problems will fall into what I call a complicated DRG, and that is paid for differently than the simple DRG itself. So there is a small refinement of difference now.

We think it is important for us to continue the research in order to more clearly target that. And we are devoting quite a number of our dollars in our research budget to look into that.

Mr. MCCAIN. Dr. Davis, it appears that there are a number of experimental programs going on in the States as far as Medicaid is concerned.

Would you comment on any of the State's programs as being successful both from the economic side as well as providing of health care?

Dr. DAVIS. Yes, sir.

I think that quite a number of the States now. I think it is about 45 of the States have now embarked upon what we call a program where we give a waiver to pay for home and community-based services, those services that are delivered outside of the normal health care area, but are more social support services.

And those programs, on the whole, seem to have been quite successful. The important thing is, of course, is to target the dollars to those that would otherwise be in an institution.

There can sometimes be a temptation to simply expand the program, which would encompass payment for those who can indeed pay for their own services. But we think on the whole that enormous strides have been made in that particular aspect.

So, I think that the major breakthrough that I have seen, in terms of the Medicaid Program has been the looking at that particular area.

Likewise, too, the experimental program in New York State that was a nursing home without walls, I think, led us into further refinements in this whole area. I was reminded, too, of some work done in terms of the payment systems themselves; some of the early work was done looking at West Virginia and some of the other States in that area.

The Arizona project is another one, of course, where we have gone into a capitated management system for providing the whole breadth of services that are needed within a managed care system, much like an HMO.

And California has embarked upon a competitive bidding strategy asking the hospitals to bid for provision of services for the Medicaid population.

So, I think those are some of the experimental activities that we have been involved in.

Mr. MCCAIN. Thank you.

Thank you, Mr. Chairman.

Mr. SISISKY. Thank you.

Dr. Davis, we understand you have a tight schedule, and I may submit some questions for the record.

I just want to follow up one question that Mr. McCain, Counsel McCain talked about at the beginning, and that's the hospital insurance trust fund.

Nothing frightened my constituents more—my senior citizens more—than the fact of the report that this would be bankrupt or depleted in 1987, and nothing cheered them up more when the report came out that it would be safe until 1998, I believe.

Are these figures still accurate, in your opinion? I know it was a late study, but how late?

Dr. DAVIS. Yes, sir. They are.

I agree with you. Nothing cheered me up more; I was haunted by that sudden, sharp decline and going off of the chart.

I used to wake up at night seeing that, and I must say we were all very heartened by the fact that we had delayed that.

I think that proves that when we are given time we can redesign the programs, and we will guarantee the sovereignty of that program, for all of our elderly citizens who not only need it now, but for some of us who will undoubtedly need it someday.

Mr. SISISKY. Good. I thank you very much, Dr. Davis, and your associates. We wish you success in whatever field you go in.

We also wish you a very, very enjoyable vacation.

Dr. DAVIS. Thank you.

Mr. SISISKY. Also, I'd like to thank Dr. Branch and Dr. Friedman for their excellent, excellent study. The committee is deeply grateful to you.

We would like to thank Mr. Gann and his wife for testimony here this morning, and the committee will stand adjourned.

Thank you.

[Whereupon, at 12:06 p.m., the hearing was adjourned.]

APPENDIX

Statement of Edward R. Royal, Chairman, Select Committee on Aging, on America's Elderly at Risk—an Analysis of Present and Future Health and Long-Term Care Costs of America's Elderly

EXECUTIVE SUMMARY

In America today, there are those who claim that the elderly are "well off" and can easily afford to absorb cutbacks in Social Security, Medicare and Medicaid. Nothing could be further from the truth. While in some ways the elderly are better off than they were 50 or even 20 years ago, they remain at great risk when it comes to paying for the health care they so desperately need.

Two studies of elderly health care costs sponsored by the House Select Committee on Aging clearly show the dilemma faced by the elderly. While everyone concedes that the Medicare program has long term financial problems, many people fail to recognize that the elderly also face great financial risk.

According to Committee estimates, America's aged will spend $1,660 in 1985 for health and long term care — over 15 percent of their already limited incomes. This year is the first in which the elderly will spend more of their income on health care than they did when Medicare and Medicaid began. The situation will only get much worse over the next five years. The Committee projects that by 1990, elderly out-of-pocket spending will grow to $2,583 — a whopping 18.9 percent of their income.

While these estimates speak to the "average elderly", a second study conducted at the request of the Chairman by researchers at Harvard Medical School and Blue Cross/Blue Shield of Massachusetts, "A Case Study of Financial Risk from Massachusetts," documents the frighteningly high financial risk facing those elderly with chronic and disabling illnesses.

Based on surveys of elderly living in the community in Massachusetts, 63 percent of elderly persons aged 66 and older living alone will impoverish themselves after only 13 weeks in a nursing home. For married couples 66 years and older, one out of three (37 percent) will become impoverished within 13 weeks if one spouse requires nursing home care.

The financial risk of caring for an Alzheimer's victim at home is also high. Survey data show that one of six married couples (16 percent) aged 66 and older risk impoverishment after 13 weeks of home care, and nearly half (46 percent) face impoverishment after one year. The analysis of financial risk among the elderly in Massachusetts is illustrative of what is happening to the elderly across the country.

This situation is deplorable and demands the immediate attention of the Congress. The Congress should act to limit elderly out-of-pocket costs so they do not rise beyond the current level of 15 percent of income. The Congress should also take immediate steps to develop and implement a coherent long term care policy which protects America's aged from impoverishment due to chronic and disabling illness.

INTRODUCTION

America's elderly are at risk. Recent attempts to cast the elderly as "well-off" belie the fact that as a group, the elderly are more vulnerable to chronic, disabling diseases than their younger counterparts. This added health risk comes with a hefty price - rising out of pocket costs for health and long term care.

No sector of America's aged is totally immune from the health and financial consequences of catastrophic and chronic illness. For the unsuspecting elder struck with an illness such as Alzheimer's disease, the risk of impoverishment is real and extends further into the middle income levels than most of us care to realize.

The nature of the elderly's health risks and the reach of related financial risks across income levels is the subject of this report. Presented in the report is documentation of the elderly's increased financial risk based on new data from a case study of elderly in Massachusetts and on an analysis of the elderly's out-of-pocket costs using data from the Health Care Financing Administration. The statement these analyses make is clear -- the majority of America's elderly remain virtually unprotected against the devastating costs of chronic illness.

Health care is a major concern of the elderly. Not only are they more susceptible to health problems than any other group, but a proportionally larger percentage of their personal resources are spent obtaining the health care they need. And this proportion is growing. In 1985 the elderly will spend over 15 percent of their income on health care - an average of $1,660 per person. The Committee projects that from 1984 to 1990, the elderly's expenditures for health care will rise twice as fast as their income. By 1990, 18.9 percent of the elderly's income will be spent on health care, an average of $2,583 per person annually.

Adding to the elderly's risk is a system of care ill-suited to their needs. The elderly are plagued with chronic illnesses while our system of care is oriented toward acute illnesses. Furthermore, many elderly find themselves without the necessary social supports, either from family or the community, to deal with these chronic conditions. Also lacking is a financing system to protect the elderly against the high costs of long term care.

Rather than moving to correct these deficiencies, recent measures taken by the federal government to contain health care costs have resulted in cutbacks in Medicare and Medicaid. These cutbacks only add to the elderly's risk and threaten the quantity and quality of care they receive in all treatment settings: the hospital, the physician's office, the nursing home, the community, and the home.

THE ELDERLY AT RISK

The Numbers of Elderly Are Increasing

Greater numbers of Americans are enjoying longer lives. In 1960, 9.2 percent of the population was age 65 and over but by 1990, 12.7 percent of the total population will be in this group. By 2010, this will rise to 13.8 percent. In the year 2030, it is projected that 21 percent of the U.S. population will be age 65 and older - nearly double the 1990 estimate. In absolute numbers this means that there will be 31.5 million elderly in 1990, 39 million in 2010 and 64.5 million in 2030.

The population of elderly 75 years of age and older is growing faster than any other age group. Between 1990 and 2010, the number of people age 75 and over will go from 13.6 million to 18.8 million. By 2030, there will be a staggering number of people - 30 million - age 75 and above.

The price of reaching old age, however, is the risk of living with impaired health and of having to exhaust one's financial resources to obtain needed health care. Far too many of our elderly spend the end of their lives in poor health and without dignity because they impoverish themselves while trying to pay for their health care.

The Elderly Have Greater Health Care Needs

The magnitude of the health care problems of America's elderly cannot be overlooked. The elderly are at greater risk than their younger counterparts of chronic, debilitating conditions such as heart and circulatory diseases, diabetes, arthritis, dementias such as Alzheimer's disease, and strokes. (Table 1.) It is estimated that 86 percent of the elderly have some chronic condition, 47 percent of the elderly living in the community have limited activity due to chronic illnesses and 18 percent have limitations of major activities. Survey data has also shown that the proportion of people with multiple diseases increases with age. It is estimated that the noninstitutionalized elderly have an average of three chronic conditions and that this rises to five among the institutionalized elderly population.

TABLE 1
Prevalence of Selected Impairments - 1981
(per 1,000 persons)

	All Ages	65 +
Visual Impairments	40.4	136.6
Hearing Impairments	82.9	283.6
Arthritis	12.1	464.7
Orthopedic Impairments	81.8	128.2
Heart Conditions	76.4	277.0
Hypertensive Disease	113.4	378.6
Arteriosclerosis	15.1	97.0
Emphysema	9.3	42.9

Often continual long term care, either in an institution or at home, is necessary. This care is costly and can consume a substantial proportion of the elderly's resources, leaving them in financial jeopardy. A case in point is Alzheimer's disease which affects five to seven percent of the elderly between 60 and 80 years of age. Of those 80 years and older, an estimated 20 to 30 percent are afflicted with Alzheimer's or other dementias. This devastating disease, which affects the rich and poor alike, is an irreversible, steadily deteriorating condition that often requires years of costly nursing home care. In many cases, the same elderly who saw themselves as financially secure at age 60 or 65 find themselves in a financial crisis within months after paying the unexpected costs of long term care for such lengthy illnesses.

The Elderly's Access To Quality Care Is Being Threatened

The current emphasis on health care cost containment places an added burden on the elderly. Many elderly are being discharged from hospitals "sooner and sicker" than is medically appropriate. As a result, their need for home health and nursing home services is greater. The major catalyst behind this trend is the prospective payment (DRG) system adopted by Medicare to contain hospital costs by limiting the length of stay in the hospital. Since the adoption of this system and, especially, since Medicare began limiting DRG payments, home health care agencies and nursing homes have noted an increase in the severity of illness among the elderly needing their care.

Tragically, the elderly find themselves increasingly unable to get the long term care they need due to the lack of available nursing home beds and restrictions on the few public programs that cover this type of care. Even when the elderly are eligible for Medicare or Medicaid, the amount of services and level of care covered are often inadequate.

The result is that more sick elderly are in the community, left to care for themselves and being burdened with increasing levels of out-of-pocket costs. Often, they have no choice but to use more and more of what limited resources they have or go without the needed care.

The Elderly Have Little Protection Against Rising Health Care Costs

Not only are the elderly more vulnerable to ill health, they also face severe risks financially in obtaining health care. No segment of the elderly population is completely protected from these financial risks and often the results are catastrophic. Our current public and private insurance programs offer little, if any, coverage for long term care, with the exception of Medicaid. The existing insurance systems are designed primarily to cover hospital care for acute illness and do little to protect the elderly from the costs of chronic illness. The small amount of long term care that is covered is "short-term" long term care — limited recuperative care following an acute hospital episode.

As a result of higher risk of chronic illness and the limited support from public and private insurance programs, America's elderly are facing ever increasing financial risks. The following two chapters examine the issue of financial risk in greater depth. The next chapter takes the perspective of the "average elderly" and the problem of rapidly rising out-of-pocket health care costs. The subsequent chapter examines the special risks for those elderly who are in need of long term care and risk becoming impoverished as a consequence.

THE ELDERLY AT FINANCIAL RISK

According to an analysis conducted by the House Select Committee on Aging, the elderly's health care costs have increased substantially in the last five years. Measured as a percentage of income, the burden is now higher than when Medicare and Medicaid began nearly twenty years ago. Over the next five years, the proportion of their income devoted to health care will continue to increase rapidly. Between 1984 and 1990, the elderly's health care payments will rise at a rate almost twice as fast as their income.

The Elderly's Out-of-Pocket Costs Will Increase Substantially Between 1980 and 1990.

Elderly out-of-pocket health care costs in 1980 were $966. Since that time, these costs have risen rapidly to a 1985 level of about $1,660 per elderly person. Out-of-pocket costs will increase even more rapidly at least through 1990 when the average out-of-pocket health care cost will be $2,583 per elderly person. Elderly out-of-pocket costs in 1990 will be over two and one-half times higher than they were a decade earlier. (Figure 1.)

Elderly Out-of-pocket Costs Are A Higher Percentage Of Income Than When Medicare And Medicaid Began.

In terms of out-of-pocket health care costs, the Committee's study shows that the elderly in 1985 are significantly worse off than the elderly were in 1977 and 1980. The elderly's health care costs grew from just over 12 percent of their income in both 1977 and 1980 to approximately 15 percent last year. In 1985, they will spend just over 15 percent of their limited income — more than when Medicare and Medicaid began.

Unfortunately, even greater problems loom in the future. The Committee projects that the portion of elderly income that goes for health care will balloon to 18.9 percent by 1990. (Figure 2.) Although Medicare and Medicaid are supposed to protect the recipients from financial disaster due to illnesses, the elderly at the end of this decade will be using substantially more of their income for health care than when Medicare and Medicaid were implemented.

Elderly Out-of-pocket Costs Will Rise Twice As Fast As Elderly Income.

During the period from 1977 to 1980, health care costs rose at a fairly high rate of 10.7 percent annually. The elderly's income grew at annual rate of 9.0 percent during those years and was almost able to keep pace with the growth in health care costs. In addition, the difference between the growth rates for elderly health care payments and income was less in that period than in later periods. Between 1980 and 1984, the elderly's health care costs grew at an annual rate of 12.1 percent while their income grew at the much slower rate of 8.1 percent.

From now until the end of the decade, the elderly's financial burden will grow even faster than in the 1977-1984 period. Over the period from 1984 to 1990, the elderly's health care payments will rise at a rate about twice as fast as their income. Specifically, the elderly's share of health care costs are estimated to climb at a rate of 9.1 percent while elderly income is expected to increase at an annual rate of only 4.6 percent. (Figure 3.)

High Elderly Out-of-pocket Costs Are A Consequence Of Inadequate Financing For Chronic Care.

The inadequacy of our financing system for long term care is a major cause of increased out-of-pocket costs. Nearly two-fifths (38 percent in 1990) of elderly health care costs will be paid by the elderly themselves. In 1990, the Committee estimates that 55 percent of nursing home costs will be paid out-of-pocket by the elderly, along with 52 percent of physician costs and 66 percent of the costs of drugs and other care, including home health care. This can be compared with the 15 percent of acute hospital care paid out of pocket by the elderly. (Figure 4.)

While Medicaid does pay for a substantial amount of long term institutional care, it is only for the poorest of the poor. In Massachusetts alone, an estimated 75 percent of nursing home beds are occupied by Medicaid patients. However, to become eligible for Medicaid, the recipients must be poor or must "spend down" by depleting most of their assets. That 75 percent of all nursing home patients in this one state are covered by Medicaid illustrates the urgent need for changes in health care coverage to guard against the elderly's economic devastation.

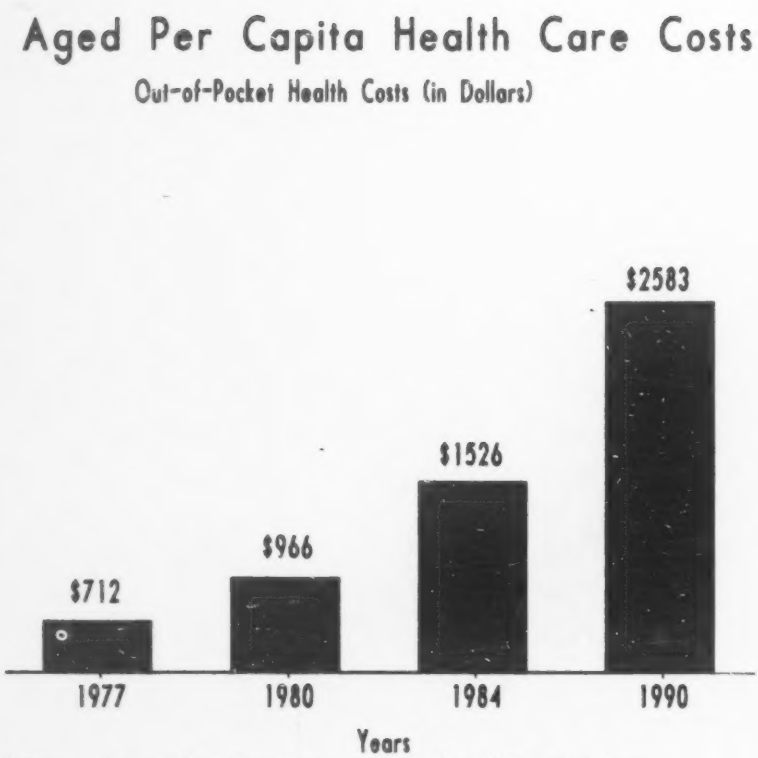
This spend down requirement poses severe economic hardships, especially for elders who have spouses in a nursing home but must continue to support themselves financially. Currently, as many as two thirds of nursing homes patients who enter as private paying patients subsequently deplete their resources and have to turn to Medicaid.

Consequences For Elderly Of Medicare And Medicaid Budget Cuts And A Failure To Contain Health Care Costs

Four years worth of cutting Medicare and Medicaid and failing to contain health care costs has taken a devastating toll on the elderly's financial resources. Assuming that the elderly should be using no greater a percentage of their income than in 1980, program cuts and the failure to control health care costs have increased the elderly's out-of-pocket health care payments in 1984 by nearly $6.8 billion — an added $242 per elderly person.

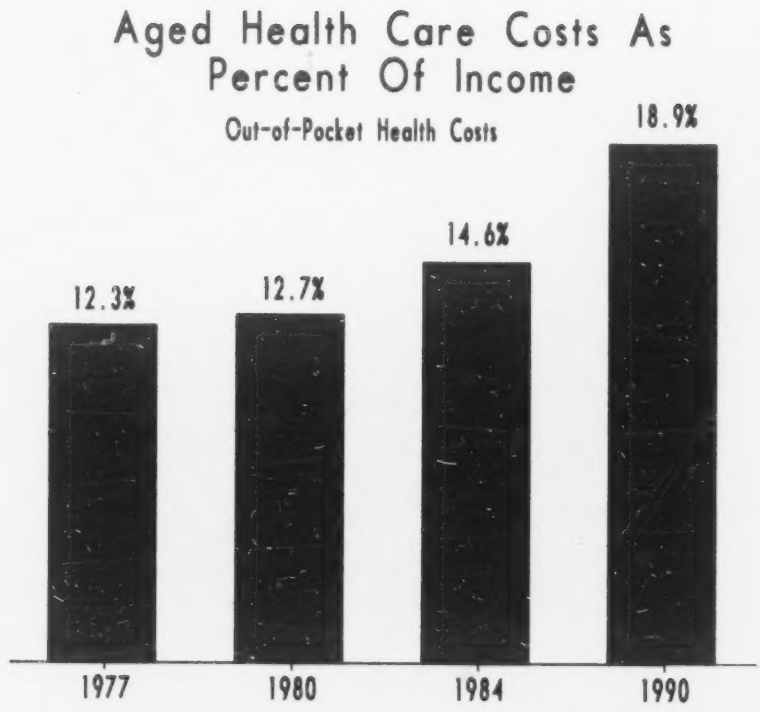
Every year that there continues to be a failure to control the elderly's share of health care costs, America's elderly will get deeper and deeper into trouble. Looking ahead to 1990, these policies will add $28.7 billion to the elderly's health care burden — an additional $900 per elderly person. This will occur even without any further cuts in Medicare and Medicaid.

FIGURE 1



Source: House Select Committee on Aging, July 1985. Health Care Financing Administration, July 1985. Census Bureau, July 1985.

FIGURE 2

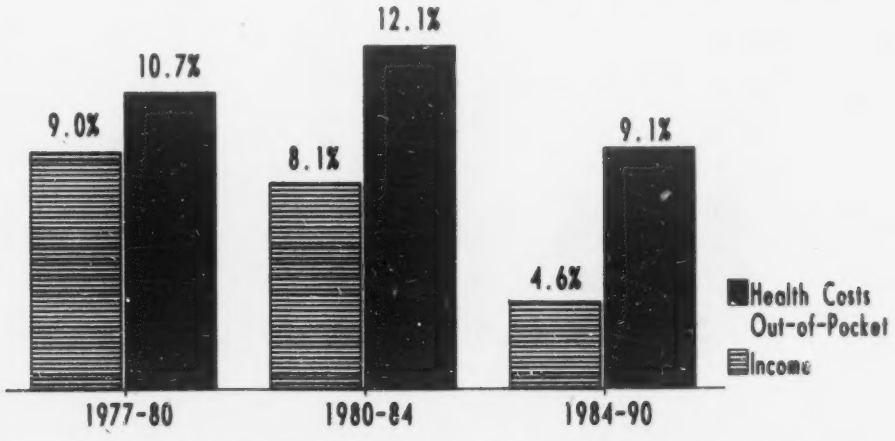


Source: House Select Committee on Aging, July 1985. Health Care Financing Administration, July 1985. Census Bureau, July 1985.

FIGURE 3

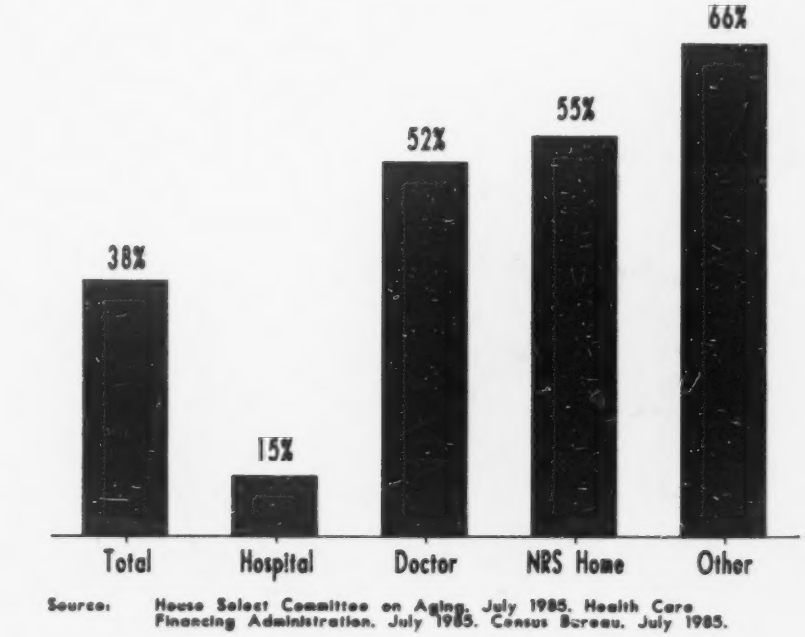
Aged Income and Health Cost Increases

Annual Percent Increases



Source: House Select Committee on Aging, July 1985. Health Care Financing Administration, July 1985. Census Bureau, July 1985.

FIGURE 4



Source: House Select Committee on Aging, July 1985. Health Care Financing Administration, July 1985. Census Bureau, July 1985.

THE ELDERLY AT HIGHEST FINANCIAL RISK

The Massachusetts study of financial risk associated with the need for long term care clearly shows that it is this population of elderly - those with chronic illnesses requiring extended home or nursing home care - that are at highest risk physically and financially.

These individuals typically fall into three categories of patients -- those who enter a nursing home for rehabilitation and will be discharged to their own home within three to six months; those who enter a home for terminal care and will die within six to twelve months, and those who remain in a nursing home indefinitely in a state of dependency.

Research on the elderly has not, however, focused sufficient attention on the financial outcomes for elders and their families of long term nursing home and home health care. The collaborative analysis undertaken by researchers at Harvard Medical School and Blue Cross and Blue Shield of Massachusetts gives us a glimpse of the financial model of health risk and the financial outcomes associated with nursing home and home health care. Their results are startling.

Among those elders surveyed aged 66 years older who live alone, nearly two out of three (63 percent) run the risk of spending down to impoverishment after only 13 weeks of nursing home care. A total of 83 percent would spend down after only one year in a nursing home. Further, if one spouse in a married household is placed in a nursing home, both the institutionalized person and the spouse run the joint risk of impoverishment at alarming rates. Approximately one out of three households (37 percent) in which both spouses are aged 66 and older would become impoverished within 13 weeks. It is important to bear in mind that in these cases, all the subsequent health care costs of the spouse who remains in the community and is improverished will likely become the financial responsibility of Medicaid.

Though it is clearly less costly to care for a dependent elder at home, the financial risks of home care are also staggering. For example, among households with both spouses aged 66 years and older, 16 percent risk impoverishment within 13 weeks and nearly half (47 percent) within one year.

What are the implications of the alarming projections borne out by the Committee's out-of-pocket cost study and the Massachusetts data? First and foremost, the elderly are being asked to bear more and more of the burden of health care costs. Added to this is their risk of financial destitution resulting from institutionalization or extended home care — a risk that reaches further into the higher elderly income levels than most people expect. In this respect, the risk faced by elders in Massachusetts is a warning of the risk of elderly Americans nation-wide.

A CALL FOR FEDERAL ACTION

What should be done about the risk of health-related impoverishment? Reduce the risk through federal action. The elderly's out-of-pocket expenses for health and long term care have risen substantially because of the failure of government to provide adequate protection. Because of inaction, more and more of the burden of this country's health care bill has been shifted to the most vulnerable of all Americans — the elderly and poor.

This trend cannot be allowed to continue. Only through political and administrative actions can these individuals be protected against the financial consequences of catastrophic illness and chronic disease. The elderly's out-of-pocket costs cannot be permitted to rise above already inflated levels. Nor should the elderly continue to go unprotected against the dire financial consequences of catastrophic and chronic illness.

In 1965, when Medicare and Medicaid were enacted, older Americans were led to believe that catastrophic health care costs would not lead to their impoverishment. In 1985, this risk still exists. While the Committee encourages other studies to further document the financial risk of elderly Americans across the country, Congress cannot afford to wait. The elderly's risk demands a call for federal action.

Toward this end, this Committee will work over the months ahead to see that the Congress acts to:

- o Limit the elderly's out-of-pocket costs to no more than the current level of 15 percent of income, and

- o Implement a coherent policy for long term care that will protect America's aged from impoverishment in the face of chronic and disabling illnesses.

APPENDIX A

METHODOLOGY AND DATA SOURCES FOR ESTIMATING ELDERLY OUT-OF-POCKET HEALTH CARE COSTS

Data sources for the analysis are primarily data and studies from the Health Care Financing Administration (HCFA). The two primary HCFA studies are "Demographic Characteristics And Health Care Use By The Aged In The United States: 1977-1984" (Fall, 1984) and "Health Spending Trends In The 1980's: Adjusting To Financial Incentives" (Summer, 1985). Medicare expenditure projections for 1985 through 1990 were also supplied by HCFA. Consumer price index projections are those used by HCFA as well. Population projections were provided by Bureau of the Census.

The projection model was developed by Committee staff and builds upon an adjusted HCFA estimate of health care costs for the elderly for 1984. Projections are made for each major component of health care expenditures (hospital, physician, nursing home, and other care) and for each source of payment (out-of-pocket, private insurance, Medicare premiums, other private, Medicare, Medicaid, and other government). The projections of each component are based on estimated population growth rates, price inflation and shifts in health care utilization.

TABLE A-1

**PERSONAL HEALTH CARE EXPENDITURES
FOR PEOPLE AGED 65 AND OLDER
IN 1977, 1980, 1984 AND 1990**

	PER CAPITA HEALTH EXPENDITURES			
	1977	1980	1984	1990
SOURCE OF FUNDS	$	$	$	$
Total	1,785	2,515	4,157	6,803
Private	719	976	1,543	2,608
Consumer	**712**	**966**	**1,526**	**2,583**
Out-of-Pocket	522	721	1,072	1,815
Insurance	115	148	308	535
Medicare Premiums	75	96	146	234
Other Private	7	10	17	24
Government	1,066	1,540	2,614	4,195
Medicare	713	1,061	1,832	3,036
Medicaid	249	333	543	835
Other Government	104	146	239	325

SOURCES: House Select Committee on Aging, July 1985; Census Bureau, July 1985; Health Care Financing Administration, July 1985

TABLE A-2

PERSONAL HEALTH CARE EXPENDITURES
AS A PERCENTAGE OF INCOME
FOR PEOPLE AGED 65 AND OLDER
IN 1977, 1980, 1984 AND 1990

ELDERLY CONSUMER COSTS AS PERCENTAGE OF INCOME	YEAR			
	1977	1980	1984	1990
% of Mean Income	12.30%	12.68%	14.62%	18.88%
% of Median Income	18.40%	18.53%	21.40%	-

SOURCES: House Select Committee on Aging, July 1985; Census Bureau, July 1985; Health Care Financing Administration, July 1985;

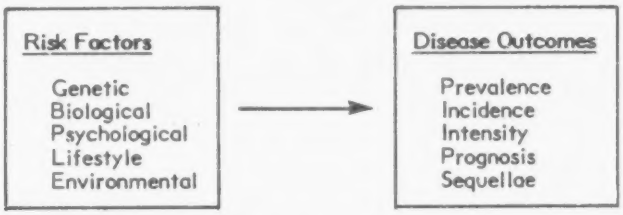
A Case Study of Financial Risk From Massachusetts

(A Report to the Chairman of the House Select Committee on Aging by Laurence G. Branch, Ph.D., Associate Professor, Department of Social Medicine and Health Policy, Harvard Medical School and Daniel J. Friedman, Ph.D., Manager, Elinor Socholitzky, MBA, Senior Program Consultant, Blue Cross and Blue Shield of Massachusetts)

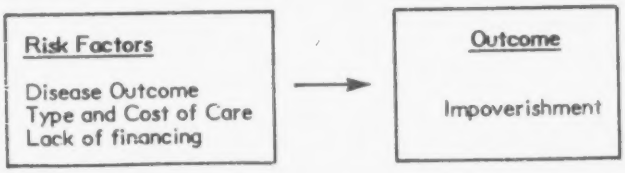
The theme of our ~~testimony~~ Report is the elderly at highest financial risk. Based on two statewide surveys, we were able to calculate the number of weeks it takes older people living in the communities of Massachusetts to become impoverished once institutionalized or once a regimen of home care has begun for a spouse with Alzheimer's disease.

The Elderly at Greatest Health and Financial Risk

The elderly face two types of health risks. The first is the traditional biomedical model that describes specific health outcomes of diseases and conditions and the risk factors associated with those outcomes. Under this model, risk factors such as one's genetic, biological and psychological makeup as well as aspects of one's lifestyle and physical environment contribute to disease outcomes.



The second type of health risk is not biomedical but financial. The financial model of health risk reflects the risk of poverty following the onset of a chronic disease or a disabling condition. In the financial model, the risk factor is the disease or disabling condition itself and the risk is that of financial devastation resulting from costly health and long term care services.



It is this population of elderly - those with chronic illnesses requiring extended home or nursing home care - that are at highest risk physically and financially.

Using the example of institutionalization, regardless of cause, as a disease outcome under the biomedical model, we can specify some of the antecedent risk factors. These include advanced age, living alone, cognitive impairment, urinary incontinence, reliance on ambulatory aids, and the need for assistance with activities of daily living such as bathing, dressing, eating, housekeeping, grocery shopping, and food preparation.

We also can specify some of the parameters of this outcome. For example, prevalence rates for nursing home use by age are 1-2 percent for U.S. elders aged 65 to 74, five to six percent for those 75 to 84 years of age and approximately 22 percent for those aged 85 years and older. Furthermore, one in four of all people 65 years and older will enter a nursing home before their death.

These individuals typically fall into three categories of patients — those who enter a nursing home for rehabilitation and will be discharged to their own home within three to six months; those who enter a home for terminal care and will die within six to twelve months, and those who remain in a nursing home indefinitely in a state of dependency.

Research on the elderly has not, however, focused sufficient attention on the financial outcomes for elders and their families of long term nursing home and home health care. Our collaborative analysis provides a glimpse of the financial model of health risk and the financial outcomes associated with nursing home and home health care.

The Elderly in Massachusetts - A Study of Financial Risk

Traditional epidemiology tells us little about the antecedent risk factors associated with Alzheimer's disease. Risk factors such as advancing age, neurotransmitter deficiency and diet have been postulated, but consensus remains elusive. Our knowledge about the parameters of the disease outcome is no more advanced. Estimates of prevalence vary widely and suggest that five to seven percent of those age 60 to 65 may suffer from Alzheimer's disease to varying degrees, while as many as 20 to 30 percent of those over age 80 may be victims of Alzheimer's or other dementias.

The Massachusetts analysis looks at the elderly's risk of impoverishment subsequent to a chronic, disabling condition such as Alzheimer's disease. Based on two surveys with a total of over 900 elderly Massachusetts residents living at home, the analysis examines the financial implications of home and nursing home care for victims of Alzheimer's disease and their spouses.

The logic of analyzing financial risk subsequent to nursing home care or home care for an Alzheimer's patient is simple. Each older person or couple has a certain amount of income and liquid assets. If an elderly person enters a nursing home or requires extended home care, one can calculate the number of weeks it will take before the individual's or the couple's income and liquid assets have been spent down to Medicaid eligibility levels based on estimated nursing home and home health costs.

Study Samples

The data on elderly income and assets used in the financial risk analysis were based on two recent collaborative statewide surveys in Massachusetts.

The first survey is the fourth in a series of interviews with Harvard Medical School's Massachusetts Health Care Panel Study. The panel began in 1975 with a statewide area probability sample of housing units. From this sample, 1,625 noninstitutionalized people aged 65 years and older were identified and agreed to participate in the study (79 percent of all those eligible). In 1985, 541 noninstitutionalized persons (aged 75 years and older by this time) were interviewed for the fourth time. Each was asked to provide 1984 income and liquid asset information as part of the interview. Among them, 200 lived alone and 88 lived in husband/wife households.

The second survey on which the financial risk analysis is based was conducted by Blue Cross and Blue Shield of Massachusetts in 1985. Based on a statewide area probability sample of housing units, 374 noninstitutionalized respondents aged 66 and older (75 percent of all those eligible) also provided 1984 income and liquid asset information. Respondents included 111 elders living alone and 98 husband and wife households.

Both the HMS and the Blue Cross/Blue Shield samples are representative of the elderly populations from which they were selected. However, the analytic samples of households selected for the specific analyses reported here are based on several limiting criteria including: household type (living alone or married and living only with spouse); age of both spouses (for HMS, both age 75 and over, for Blue Cross/Blue Shield, both age 66 and over); completion of interviews with both spouses; and provision of all requested income and asset data. The limiting criteria used for these analyses have affected sample sizes, and the results reported here should be regarded as suggestive.

Long Term Care Cost Assumption

In Massachusetts, the estimated 1984 statewide private pay rate charged most frequently in a skilled nursing facility was $75 a day which is over $27,000 annually.

Data on the costs of home-based care are difficult to derive. Based on a recent analysis, Alzheimer's patients require an average of 6.28 hours of homemaker or home health aide assistance per day (Hu, Huang and Cartwright, in press). In Massachusetts, the 1984 average wage and benefit rate for contracted homemaker/home health aide services was $5.69 per hour. The average daily home care cost for an Alzheimer's victim was therefore estimated at $35.00 (6.28 hours times $5.69 rounded down to nearest dollar), or nearly $13,000 per year.

Impoverishment Assumptions

For the purpose of the Massachusetts analysis, an elderly person was considered eligible for Medicaid only after their self-reported 1984 liquid assets had been spent down to $1,000 and only if their self-reported 1984 income was spent down to no more than $4,000 - a level well below national poverty guidelines. In the case of couples, joint liquid assets of no more than $3,000 and income of no more than $5,000 were used to approximate Medicaid eligibility.

Health and Economic Profile of Study Samples

A summary of the sociodemographic characteristics of the two samples available for the Massachusetts analysis is presented in Table 1.

Study Results

Table 2 and Figures 1 and 2 present the number of weeks it takes older people living in the communities of Massachusetts to become impoverished once institutionalized or once a regimen of home care has begun for a spouse with Alzheimer's disease. Among the Harvard Medical School sample of elders 75 years of age and older who live alone, approximately half (46 percent) run the risk of spending down to impoverishment after only 13 weeks of nursing home care. Only one of four people in this same sample would escape impoverishment in the first year following nursing home placement. Among the slightly younger (66 years and older) Blue Cross and Blue Shield sample, nearly two out of three elderly (63 percent) living alone are at risk of impoverishment by the 13th week of institutionalization.

If one spouse in a married household is placed in a nursing home, both the institutionalized person and the spouse run the joint risk of impoverishment at alarming rates. Among the older Harvard Medical School respondents, approximately one of four households (25 percent) in which both spouses are aged 75 and older would become impoverished within 13 weeks. One out of three (37 percent) of all households aged 66 and older would become impoverished in the same time period. It is important to bear in mind that in these cases, all the subsequent health care costs of the spouse who remains in the community will likely become the financial responsibility of Medicaid.

The financial risks of caring for an Alzheimer's victim at home are also staggering. Among the Harvard Medical School households with both spouses aged 75 years and older, one out of ten households (11 percent) risk impoverishment within 13 weeks, and two out of five (41 percent) within one year. Among the younger Blue Cross and Blue Shield sample, one of six married households (16 percent) risk impoverishment within 13 weeks and nearly half (47 percent) face impoverishment within one year.

The Implications

What are the implications of these alarming projections? First and foremost, the risk of becoming financially impoverished following institutionalization or after paying for home care influences the majority of all elders, not just low income elders.

Is this finding inconsistent with the often-heard assertion that the vast majority of our country's elderly are in financial control of their own lives? Not at all. Statements about the economic well-being of our elders are usually made only in the context of predictable costs and expenses and without giving full consideration to their reliance on fixed incomes. From the perspective of most elderly persons living alone or with a spouse, the daily rates for home care or nursing home care are unpredictable catastrophic expenses that exceed their life savings relatively quickly.

How many older people are actually at risk of impoverishment? While we lack definitive data on the numbers of elderly at risk of extended in-home or nursing home care, the available data paint a bleak picture.

For the vast majority of the victims of Alzheimer's disease, nursing home care and the associated costs are inevitable. Based on preliminary data on the prevalence of Alzheimer's disease, as many as five to seven percent or two million older Americans between 60 and 80 years of age are potentially at risk of needing costly home or nursing home care at some point in their lives for this disease alone. Beyond this group are numerous others who will suffer from other debilitating diseases requiring constant care.

The likelihood of impoverishment is extremely high if an elderly person is placed in a nursing home or needs extensive home care on a prolonged basis.

TABLE 1

SELECTED CHARACTERISTICS OF HOUSEHOLDS ANALYZED FOR FINANCIAL RISK ANALYSIS

	Blue Cross/ Blue Shield Age 66 +		Harvard Medical School Age 75 +	
Household Composition				
Alone	69%	(111)	82%	(200)
With Spouse	31%	(49)	18%	(44)
TOTAL	100%	(160)	100%	(244)
Age of Head				
66 to 74	52%	(82)	—	—
75 to 84	40%	(64)	77%	(189)
85 +	8%	(13)	23%	(55)
TOTAL	100%	(159)	100%	(244)
Gender of Head				
Female	56%	(89)	64%	(156)
Male	44%	(71)	36%	(88)
TOTAL	100%	(160)	100%	(244)

TABLE 1 (Continued)

	Blue Cross/ Blue Shield Age 66 +		Harvard Medical School Age 75 +	
Home-Ownership				
Owns	38%	(61)	43%	(106)
Rents	61%	(98)	53%	(130)
Other	1%	(1)	3%	(8)
TOTAL	100%	(160)	99%*	(244)
Self-Reported Household Income				
$5000 and Under	21%	(33)	26%	(63)
$6000 - $10,000	51%	(82)	51%	(124)
$11,000 - $15,000	13%	(21)	8%	(19)
$16,000 - $20,000	6%	(9)	9%	(21)
$21,000 and Over	9%	(15)	7%	(17)
TOTAL	100%	(160)	101%	(244)
Self-Reported Household Assets				
$1000 or Under	36%	(58)	24%	(58)
$2000 - $10,000	35%	(56)	37%	(91)
$11,000 - $20,000	8%	(12)	10%	(24)
$21,000 - $50,000	9%	(14)	14%	(34)
$51,000 and Over	13%	(20)	15%	(37)
TOTAL	101%*	(160)	100%*	(244)

* Due to Rounding

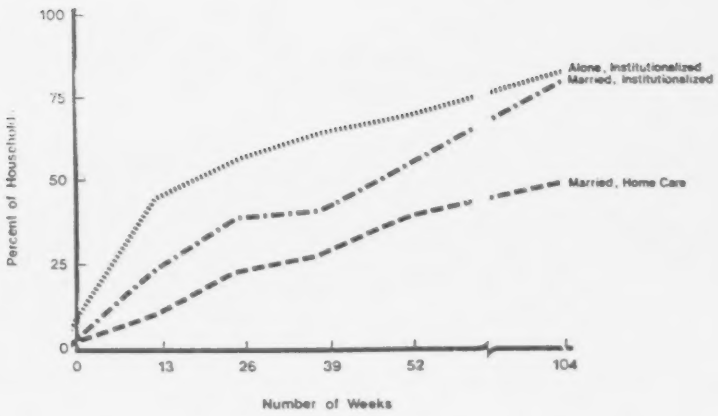
TABLE 2
PERCENT OF ELDERLY IMPOVERISHED
By Number Of Weeks

Sample	Number of Weeks 0	13	26	39	52	104
Age 75+ (Harvard Medical School)						
Alone, In Institution	7%	46%	59%	66%	72%	85%
Married, In Institution	2%	25%	41%	43%	57%	82%
Married, At Home	2%	11%	25%	30%	41%	52%
Age 66+ (Blue Cross & Blue Shield)						
Alone, In Institution	8%	63%	74%	80%	83%	91%
Married, In Institution	4%	37%	47%	53%	57%	80%
Married, At Home	4%	16%	33%	39%	47%	55%

FIGURE 1
ELDERLY AT FINANCIAL RISK

Percent Impoverished
By Number Of Weeks Of Long Term Care

Population Aged 75 + (HMS)

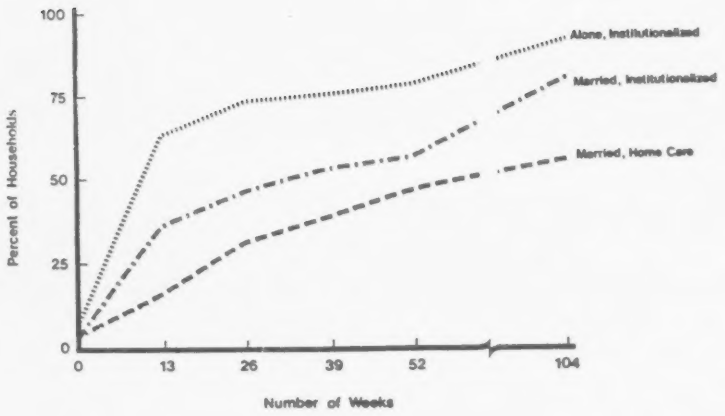


Source: L.G. Branch, Massachusetts Health Care Panel Study, Wave IV, 1985.

FIGURE 2
ELDERLY AT FINANCIAL RISK

Percent Impoverished
By Number of Weeks of Long Term Care

Population Aged 66 + (BC/BS)



Source: D.J. Friedman, E. Socholitzky, Blue Cross and Blue Shield of Massachusetts, 1985.

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STATEMENT OF THE HON. JAIME B. FUSTER
RESIDENT COMMISSIONER FOR PUERTO RICO
FOR HEARING OF HOUSE SELECT COMMITTEE ON AGING ON THE
20TH ANNIVERSARY OF MEDICARE AND MEDICAID
AMERICANS STILL AT RISK

JULY 30, 1985

Mr. Chairman, distinguished members of the House Select Committee on Aging, I am presenting testimony for the record on behalf of the people of Puerto Rico on an issue of the greatest importance to the 3.5 million U.S. citizens of our Island, which I represent as the elected Resident Commissioner and member of the United States House of Representatives.

On July 30, 1965, the Medicare and Medicaid programs were established to provide and ensure medical care for Americas aged, poor and disabled. Even though close to 50 million aged, poor and disabled receive medical services under these programs, there are still millions of Americans who remain uninsured and underinsured, and who might join the ranks of the poor when confronted by spiraling out-of-pocket expenses caused by a crippling disease. Alzheimer's disease, for example, requires long-term medical care either at home or in a specialized facility and leaves not only the affected person but whole families ruined. The majority of victims of these crippling illnesses are the elderly and these are the citizens still at risk, which you are

considering on the commemoration of the twentieth anniversary of Medicare and Medicaid.

Another area where existing Medicare/Medicaid coverage falls very short of being equitable is the treatment accorded to the 3.5 million United States citizens of Puerto Rico who have not enjoyed the benefits of Medicare/Medicaid fully.

In Puerto Rico, because of its unique socio-economic characteristics and the funding limitations imposed on it under Medicaid and other Federal programs, the hardship of a long-term care illness on our elderly is significantly onerous. To begin with, according to the 1980 census, 8% of Puerto Rico's population (248,000) was estimated to be 65 years or older. The Commonwealth's Department of Health statistics estimates that 78% of all elderly Puerto Ricans are affected by one or more chronic conditions. The 62% level of the population of Puerto Rico that falls below the poverty level supports the fact that most of our elderly are poor and would be eligible to receive long-term care services under the Medicaid program if Puerto Rico had the financial resources to provide these services. Unfortunately, this is not the case.

When the Medicaid program was established in 1965 by Public Law 89-67, the Federal Medical Assistance Percentage (FMAP) for the states was set at no less than 50% or no more than 83% based on the state's per capita income. For Puerto Rico, the per capita income factor was not considered and instead the FMAP was reduced to 50%. The $20 million ceiling was raised to $30 million in 1972, to $45 million in 1981, and to $63.4 million in 1983. Despite rising medical care costs and stringent requirements of the program, the Medicaid FMAP has remained at the 50% level for 17 years. On the other hand, Federal funding of the Medicaid program in the mainland U.S. has increased from $1.6 billion to 1966 to $20.3 billion in 1984. On a per capita basis, Puerto Rico receives $58.80 annually per eligible Medicaid recipent, while recipients in the mainland U.S. receive $894.27 anually, a difference of $835.40.

As a result of the $63.4 million ceiling and 50% FMAP of the Medicaid program for Puerto Rico, the economic basis of the program has been deteriorating due to increased demand for services and the impact of inflation. It should be noted that the cost of living in the Island is higher than in the mainland U.S. and the purchasing power of the dollar has decreased from $1.00 to $.40 in 1984. In addition, the general price index rose to 250.1 in 1984, while the medical care index rose to 313.4. The Medicaid health care system has been successful in upgrading the health of the population, but it needs additional financial support in order to serve the elderly who require long-term care.

In addition to matching the Federal contribution of $63.4 million at the imposed 50% FMAP, the government of Puerto Rico has

channeled $172.2 million into the Medicaid program in order for it to fulfill the requirements of the Joint Commission on Accreditation of Hospitals, the Medicaid program and local regulations. Despite this massive local government contribution, the cost of providing long-term care to eligible recipients is prohibitive unless additional funds are made available from the Federal government.

According to Dr. Justino del Valle, the Puerto Rican founder of the Island's Alzheimer's association, at least 20,000 elderly are suffering from this ailment, and he suspects there are several thousand more undiagnosed cases of this disease. It is Dr. del Valle's opinion that Alzheimer's disease is reaching epidemic proportions in Puerto Rico and proper medical care is not available. Instead, families are bearing the expense of caring for these unfortunate victims.

Another 5,300 incapacitated elderly are living in private institutions and homes and their care is also financed by their families. However, the fees paid to these institutions and homes are so meager that only the most basic necessities are provided. Medical care received by these patients is limited to a monthly examination and a visit in case of emergency.

There are thousands of elderly in Puerto Rico who need immediate long-term care which cannot be provided under the present health care system financed with Medicaid federal and local funds. In order to provide long-term care services to our elderly in the

same measure as in the mainland U.S., additional Federal funding is required. By adjusting the FMAP for Puerto Rico or removing the current $63.4 million ceiling, the Island would be the recipient of increased Federal funding as demonstrated by the following alternatives:

ALTERNATIVE A

Elimination of the $63.4 million federal ceiling and maintenance of the current FMAP level (50%) would result in:

$299.0 million	- Total cost of the program for Puerto Rico
50%	- FMAP
$149.5 million	- Federal contribution

ALTERNATIVE B

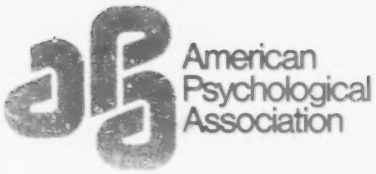
FMAP, if computed on the basis of Puerto Rico's per capita income, would amount to 83% and thus result in:

$299.00 million	- Total cost of the Medicaid program for Puerto Rico
83%	- new FMAP which would replace the current 50% FMAP
$248.1 million	- Federal contribution

The additional Federal contribution, under Alternative A, would amount to $86.1 million, and under Alternative B, it would be $184.7 million.

This hearing represents the initial step in creating effective policies to eradicate or at least minimize the financial and emotional burdens of long-term care illness on the elderly and

their families. I hope that as the Congress considers the various aspects of this issue prior to formulating new policy, it will focus in its assessment on the special situation of Puerto Rico's elderly with respect to long-term care, and the inability of the Medicaid program in the Island to offer the needed services to eligible elderly participants.



Testimony

on behalf of

The American Psychological Association

The Action Committee to Implement the Mental Health

Recommendations of the 1981 White House Conference on Aging

before the

United States House of Representatives

Select Committee on Aging

July 30, 1985

The Twentieth Anniversary of Medicare and Medicaid: Americans Still at Risk

The Honorable Edward R. Roybal, Chairman

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The American Psychological Association and the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging are pleased to have the opportunity to present this statement before the Select Committee on Aging's hearing on "20th Anniversary of Medicare and Medicaid: Americans Still At Risk." The APA and the Action Committee want to commend the Members of the Committee for their attention to this extremely important issue, and we join the celebration of the 20th Anniversary of Medicare and Medicaid. However, we agree, with the Committee that this celebration is a bittersweet one; these programs still leave many Americans at risk.

Our major concern among the nation's elderly at risk, is for those suffering from nervous and mental disorders. The Medicare benefit, for services necessary to respond to nervous and mental disorders, is unrealistically limited. The inadequacy of this benefit encourages the inappropriate use of other services and results in using the Medicaid program as a safety net. The APA and the Action Committee believe the following aspects of the Medicare benefit for nervous and mental disorders are unrealistic and result in the costly use of clinically inadequate methods of care:

1) The limitation of the overall benefit, and higher co-payment than for other health care.

2) The limitation of direct payment only to physicians.

3) The limitation of payment to certain settings.

4) The limitation on payments for long term care.

The consequences of these Medicare limitations promotes the costly and inappropriate use of alternative services and facilities, and defers to the Medicaid program for certain long term care needs of the older population.

Our statement will focus on the need to provide for the mental health and long term health care needs of our nation's elderly; 2) the fact that very limited coverage for these services has been available in Medicare since 1964; and, 3) the unfortunate role of Medicaid in providing services to the poor elderly who have exhausted their Medicare benefit and depleted their personal assets. APA and the Action Committee strongly believe the current federal role does not assure adequate health care services for persons with mental disorders or chronic conditions.

Twenty years ago the federal government designed the Medicare system to provide for health care needs of the aged population. Medicare was expressly designed to meet the acute health care needs of elderly Americans and to insure the elderly against the expenses for these services. In shaping the scope and level of coverage for service benefits, Medicare was able to draw upon only a few decades of experience with health insurance in the general marketplace, and a limited understanding and experience with the general health care needs of a large elderly population. Since then, information gained from providing health insurance coverage for mental health treatment

and our greater understanding of the chronic conditions experienced by the elderly that require care, have not been adequately incorporated into the scope and structure of the Medicare mental health benefit.

Currently, Medicare provides health care benefits for over 27 million elderly and 3 million disabled persons across the country; costs for FY 1984 were $66 billion. The costs for hospital care were recently brought under a new prospective payment system (PPS) in which hospitals are paid on a per-case basis, at predetermined rates based on the diagnosis of the patient. In some settings, mental and nervous disorders which require hospitalization come under this new system. However, specialty settings such as psychiatric hospitals and psychiatric units in acute-care hospitals are temporarily eligible for exemption from the new PPS system, and can continue to be paid according to the previous cost-based method. As we stated earlier, the benefit is limited to a lifetime maximum of 190 days of care in psychiatric hospitals. Payment for <u>all</u> out-patient treatment for nervous and mental disorders is restricted by an annual reimbursement ceiling of $250, with a 50% co-payment requirement.

Medicare's benefit levels for nervous and mental disorders have not changed since they were first instituted in 1965. The $500.00 value of services available in 1965--allowing for inflation at a standard rate of 10%--is worth less than $50.00 today. In contrast, Medicare benefits for other health services are limited only by co-payments (the standard patient contribution is 20 percent) and deductibles; and, the customary fees on which reimbursements for general health services are based are periodically

reassessed. Furthermore, the hospital portion of costs, now prospectively set, has been developed with current information. Considerable care is being taken in the implementation of this new system, to assure that a balance is maintained between the fiscal incentives to provide efficient services, and the facility's ability to deliver quality services.

The 190 day hospital benefit may be adequate for many conditions but is uterly unrealistic for persons suffering from chronic conditions whose care requires frequent hospitalization. This is a very small percentage of the Medicare population (about 3%) and the costs generated by adequately providing services for them would not be excessive.

Regarding the amount of out-patient services avaiable to Medicare Part B enrollees, if we assume customary charges are $55.00/hour, an elderly person would have barely nine sessions for mental health care available to them--for which they are expected to pay half the charges, or about $250.00. This does not compare with the minimum twenty outpatient visits mandated for federally qualified Health Maintenance Organizations, or commonly provided in private insurance plans. Some programs such as CHAMPUS allow unlimited outpatient visits per year, monitored through standardized peer review points.

Our point is unmistakable: The Medicare program offers inadequate benefits to Americans over 65 by severely limiting its coverage for both inpatient and outpatient mental health care.

Medicare's entire service delivery model also limits direct reimbursement only to physicians and insists, with limited exceptions, that all services be delivered or supervised by a physician. In the case of care for mental and nervous disorders, this is unrealistic and economically unwise as there are a large number of other mental health professionals--such as psychologists, social workers and psychiatric nurse specialists--who are qualified to provide care. The use of alternative providers for mental health care would help to assure more appropriate care at a more economical price.

The acute-care focus of the Medicare program contributes to its lack of provision of appropriate services for persons requiring mental health in long term care settings. In this regard, Medicare recognizes only the hospital or psychiatric hospital as institutional providers for mental health care and denies payment to skilled nursing facilities (SNFs) for this care. Furthermore, Medicare fails to recognize the use of institutional alternatives that could have positive implications for the financing system. Respite care and adult day care are examples of services that would lessen the burden on the financing system by helping to avoid--or at least postpone--the often necessary residential care of an aged or severely disabled population.

The long and debilitating course of many chronic diseases, which often include certain mental health problems, lead to the eventual placement of many elderly patients in nursing homes--intermediate care facilities (ICFs) and (SNFs). Medicare coverage for nursing homes is restricted to the SNF setting with many benefit limitations. Eligibility requirements for SNF care require that a patient need skilled nursing care or rehabilitative services, that they

enter the facility following a hospital stay, and that placement be for the same condition for which treatment was given during hospitalization.

When these criteria are met, a total of 100 days of nursing home reimbursement is provided; $50 per day co-payment is required between the 21st and the 100th day. After these benefits are exhausted, the patient must either make personal payments (which account for 44% of all nursing home payments), rely on private long term care insurance (less than 1% of all nursing home payments are from private health insurance sources), be discharged to the care of family or friends, or if Medicaid coverage is available, "spend down" to meet Medicaid criteria.

Intermediate Care Facilities (ICFs) are a more typical nursing home setting for the majority of elderly persons with chronic conditions requiring long term care. Although it is not covered by Medicare, most states have opted to offer some type of ICF reimbursement through their Medicaid programs--despite the lack of a federal mandate. Medicaid was created to provide health care to the nation's poor. By default, and not initially intended, it also provides payment for some of the long term care services neglected by the Medicare program. Once placement is located in an ICF, an elderly resident with a mental disorder is very likely to be at risk for receiving appropriate treatment. This phenomenon is a direct result of federal policy which discourages treatment for mental diagnosis by denying reimbursement to facilities which treat over 50% of their patients for mental disorders. This would classify the facility as an institution for mental diseases (IMD), and ineligible for Medicaid reimbursement.

Medicaid is the largest single source of financing for nursing home care, representing over 48% of all nursing home payments (a total of $13.2 billion in FY 1982). It has been estimated that as many as one-half of the nation's nursing home residents have mental disorders; the care of these residents accounts for almost $16 billion per year.

Since Medicaid is a welfare program, income is the only eligibility criteria and clients must attain a state of poverty to qualify for this type of institutional care. The need for care, itself, is not a prerequisite for eligibility. At least one-half of Medicaid nursing home recipients were not initially poor upon entering the institutional setting, but had to "spend down" to meet state Medicaid eligibility levels. The extended course of many chronic conditions, experienced by the elderly increases the liklihood that patients will exhaust their personal resources and become dependent on state Medicaid programs. Medicare's failure to address the long-term care needs of our nation's elderly will continue to "pauperize" patients with chronic disorders.

In summary, the APA and Action Committee believe that the current Medicare program leaves many Americans at risk, especially with respect to necessary care for nervous and mental disorders. The benefit limitations leave many elderly at risk of receiving inadequate care for their nervous and mental disorders. The provider limitation fails to recognize alternative mental health providers and contributes to increased costs and inappropriate care. The payment limitation for certain settings promotes inappropriate placement and often inappropriate treatment. And finally, the limitations of payment to

long term care facilities often forces payment for chronic condition to the Medicaid program. This not only complicates the elderly's ability to receive appropriate care, but reduces them to poverty levels.

The APA and the Action Committee extend our appreciation for this opportunity to present our views on the inadeqacies of the Medicare program. We hope that the Committee will continue to pursue the important issues surrounding the need for an increased federal role in the Medicare program so our aged will have access to necessary mental health care and not have to become destitute to receive benefits for their long term care needs. We offer the assistance and expertise of our two organizations in this pursuit.